Joseph K. Hyon, D.O., P.A.

Patient Registration Form Today's Date: _____ Account #: _____

Social Security #: _____
First Name: _____ MI: _____
Last Name: _____
Sex: M___ F ___ Date of Birth: ___/___/_____
Marital Status: □ Married □ Single
□ Widowed □ Divorced
□ Employed □ Retired □ Full time Student
□ Other _____

Home Address: _____
_____
City: _____ State: _____ Zip: _____
Home Phone: (___) _____
Work Phone: (___) _____
Cell Phone: (___) _____
Referring Physician: _____
How did you hear of us? _____

Employer/School: _____
Employer/School's Address: _____
Employer/School's City, State and Zip: _____

Please provide your insurance card to the front desk staff. Thank you.
If this is a Workers Compensation Case or No Fault Case, please ask the front desk staff for an additional form.

Primary Insurance: _____
Policy #: _____ Group #: _____
Insured/Policyholder's Name: _____ Relationship, if not patient: _____
Date of Birth of Policyholder: _____
Secondary Insurance: _____
Policy #: _____ Group #: _____
Insured/Policyholder's Name: _____ Relationship, if not patient: _____
Date of Birth of Policyholder: _____

What phone number can we leave confidential information such as test results or appointment information?

_____

Emergency Contact Information:
First Name: _____ Last Name: _____
Relationship: _____
Home Phone: (___) _____ Work Phone: (___) _____
Name of spouse/guarantor/responsible party:
First Name: _____ Last Name: _____
Relationship: _____ Daytime Phone: (___) _____
SS#: _____ Date of Birth: _____ Sex: M___ F ___
Address: _____ City: _____ State: ____ Zip: _____
Employer: _____
Address: _____ City: _____ State: ____ Zip: _____

Joseph K. Hyon, D.O., P.A.
74 Pascack Road
Park Ridge, New Jersey 07656
201.930.0900

Patient Registration Form (continued from Page 1)

I, the undersigned, certify that I (or my dependent) have active coverage with the above insurance company and assign directly to the above mentioned Practice all insurance benefits, if any, otherwise payable to me for services rendered.

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles required by my insurance company.

I understand that it is my responsibility to be aware of the rules of my insurance company, including but not limited to, selecting a primary care physician for HMO plans, referrals, authorizations, clinical lab services, radiological services, copays, etc.

I hereby authorize the Practice to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I, also, accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I understand that if my account is sent to a collection agency for non-payment that a $50 or 20% surcharge, whichever is greater, will be added to my balance to cover administrative costs.

Signature of Responsible Party	Relationship (if other than patient)	Date

Joseph K. Hyon, D.O., P.A.

PAST MEDICAL HISTORY INTAKE FORM

TODAY'S DATE: _____ **SS #**_____

Name: _____**DOB**_____

Reason for today's visit:

_____

_____

_____

Who referred you to this practice: _____

Allergies: Medications, Foods or Latex (if any, please list what kind of reaction):

_____

_____

_____

_____

_____

_____

Medications: include prescription drugs, over the counter medications, herbs and vitamins that you are currently taking (please list the name, dosages, and frequency): _____

_____

_____

_____

_____

_____

(use the reverse side of the page if needed……..

Pharmacy information: (Please note that it very important that you give the office accurate information. All of your prescriptions will be sent electronically. They are not sent by phone or paper.)

Local pharmacy (where you would like us to send electronic prescriptions to):

First choice-name of the pharmacy, address and phone number:

_____

_____

Second choice-name of the pharmacy, address and phone number:

_____

_____

Long-term or mail away pharmacy (where you would like us to send electronic prescriptions to for a long term supply):_____

_____

Past medical problems: Please check off those that apply and list any others not listed:

High blood pressure _____	**Emphysema _____**	**Asthma _____**
Heart disease/angina attack _____	**Diverticulosis _____**	**Allergy/hay fever _____**
High Cholesterol _____	**Pneumonia _____**	**Diabetes _____**
Stomach problems _____	**Back Pain _____**	**Migraine Headaches____**

_____

_____

_____

_____

Past surgical procedures (such as gallbladder surgery, appendectomy, tonsillectomy, biopsies and etc. Please list the name of the surgeon, hospital, when and reason for the surgery): _____

_____

_____

_____

Hospitalizations/Emergency room visits (please list dates, locations and reasons for hospitalizations):_____

_____

_____

_____

_____

_____

_____

_____

Alternative medical care (such as chiropractor, acupuncture, homeopathic medicine -please list the name and the source of the alternative medicine):

_____

_____

Family history: Please list any history such as diabetes, heart condition, cancers especially breast and colon and etc. (please include your relationship to the family member):_____

_____

Social History:

Tobacco: (list any past or present tobacco use, period of use and quantity of use and type of use - for example cigar, chewing tobacco, cigarettes, pipes, etc)

Alcohol: (List past/present alcohol use - please list period of use, quantity of use and type of alcohol use) _____

Occupation: (List past or present occupation) _____

Please list any exposure to harmful chemicals such as fumes, asbestos, etc.:

How many hours a day do you work at a computer? _____hours

Do you have pet(s)? If yes, please list: _____

Recent/past travel outside of the country: _____

Do you use recreational drugs? _____

History of blood transfusions: (If so, when, where and under what circumstances):

Current marital status: _____

Do you seasonally migrate? (Live in one location in the winter and one location in the summer) if so where? Please list address (es), phone number(s), and pharmacy (ies) of alternative location: _____

Health Maintenance History:

List any specialists that you see on a regular basis (please list name, address and phone number, reason for the visits and how often you need to see the specialist):

_____

_____

_____

Last colonoscopy: **(Please list the name of the doctor or place, date and results of your last colonoscopy:** _____

_____

****For females only:**

Please list the name, address and phone number of your OB/GYN:

_____

_____

Last mammogram: **Date:** _____ **Place:** _____
Results: _____

Last bone density: **Date:** _____ **Place:** _____
Results: _____

Last GYN exam: **Date:** _____ **Place:** _____
Results: _____

****For males only:**

Last prostate exam: **Date:** _____ **Place:** _____
Results: _____

Immunizations:

Please list immunizations by date, age when you received it, where you received it:
DPT/OPV_____
MMR #1_____
MMR #2_____
Hepatitis B vaccine #1_____
Hepatitis B vaccine #2_____
Hepatitis B vaccine # 3_____
Tetanus_____
Pneumonia shot (pneumococcal vaccine) _____
Flu vaccine_____
Gardasil (for HPV virus):_____

Living Will ? _____

Healthcare Proxy ? _____