JOSEPH K. HYON, D.O.,P.A.
PATIENT REGISTRATION FORM

Today's date: | Email:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F

Street address: | Cell Phone no: | Home phone no.: ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( )

Chose office because/Referred to office by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Full Name: | Relationship to patient: | Cell phone # ( ) | Home/ Work phone # ( )

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PATIENT REGISTRATION FORM

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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 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
261 Old Hook Road
Westwood, NJ 07675
Ph: (201)265-1133 Fax: (201)265-1135

Patient:_____

Date:_____

In connection with the medical services that I am receiving from this practice and its medical staff, I hereby authorize the physicians of this practice and respective agents to disclose any and all information concerning my medical condition and treatment (including but not limited to, super confidential information concerning sexually transmitted diseases, chemical dependence or other such information), including copies of applicable hospital medical records to:

1. Any third party payor covering the medical services of the patient.
2. Other health professionals and institutions involved in the delivery of health care to the patient.
3. The proponent of any legally sufficient subpoena, or in response to a court order.
4. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services.
5. Pharmacies, and
6. As otherwise required by law.

When providing information to me, information may be transmitted to me by any or all of the following means (initial all that apply):

_____ Telephone messages on an answering machine or voicemail.

_____ Messages the following family member or friend (only one):

Spouse_____ Child_____ Other_____

In each case, the Practice will take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have the opportunity to place special restrictions upon the consent hereby given:

Special Instructions:_____

_____

_____

This consent is valid from the date executed until revoked in writing by the patient.

Patient's Signature_____

Date_____

Signature of Patient Representative (required if patient is a minor or unable to sign this form)

_____

Relationship to Patient_____

Joseph K. Hyon, D.O., P.A
261 Old Hook Road
Westwood, NJ 07675
Ph: (201)265-1133 Fax: (201)265-1135

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize the physicians of Joseph K. Hyon, D.O.P.A. and their agents to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Joseph K. Hyon D.O., P. A. can refuse to treat me.

I have had the opportunity to review the Notice of Privacy Standards ("Notice"), which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I am entitled to a copy of such "Notice" at my request.

I understand that I may revoke this consent at any time by notifying Joseph K. Hyon, D.O., P.A., in writing, but if I revoke my consent, such revocation will not affect any actions that Joseph K. Hyon, D.O., P.A. took before receiving my revocation.

I understand that Joseph K. Hyon, D.O., P.A. has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Joseph K. Hyon, D.O.,P.A. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Joseph K. Hyon, D.O., P.A. does not have to agree to such restrictions, but that once such restrictions are agreed to, Joseph K. Hyon, D.O., P.A. must adhere to such restrictions.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed name of Patient or Patient's Representative

_____

Relationship to Patient

Joseph K. Hyon, D.O., P.A
261 Old Hook Road
Westwood, NJ 07675
Ph: (201)265-1133 Fax: (201)265-1135

Payment Agreement

I understand and agree that my co-payment, co-insurance, and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company and/or workmans comp as well as applicable co-payments and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to Joseph K. Hyon DO.

Patient Name

Date

_____ _____

Signature of Patient or Guardian

_____

[redacted]

JOSEPH K. HYON D.O.

PAST MEDICAL HISTORY INTAKE FORM

PERSONAL INFORMATION

Name: _____ Today's Date: _____

_____ DOB: _____

Reason for today's visit: _____

_____

Who referred you to this practice? _____

MEDICATION

Please list the name, dosage, and frequency of the prescription drugs, over the counter medications, herbs, and vitamins that you are currently taking:

_____

_____

_____

_____

ALLERGIES

Please list any allergies and what kind of reaction (medications, foods, or latex):

_____

_____

_____

_____

PHARMACY INFORMATION

Please note that it is 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 (name, address, phone): _____

_____

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 all that apply and list those that are not listed:

- ❑ Allergy/hay fever
- ❑ Asthma
- ❑ Back Pain
- ❑ Diabetes
- ❑ Diverticulosis
- ❑ Emphysema
- ❑ Heart disease/angina attack
- ❑ High blood pressure
- ❑ High Cholesterol
- ❑ Migraine Headaches
- ❑ Pneumonia
- ❑ Stomach Problems

❑ Other: _____

_____

PAST SURGICAL PROCEDURES

Please list past surgeries such as gallbladder surgery, appendectomy, tonsillectomy, biopsies, etc. Please list the name of the surgeon, hospital, date, and reason for the surgery: _____

_____

_____

_____

HOSPITALIZATIONS/EMERGENCY ROOM VISITS

Please list dates, locations, and reason for hospitalization:

_____

_____

_____

_____

ALTERNATIVE MEDICAL CARE

Please list the name and the source of the alternative medicine such as chiropractor, acupuncture, homeopathic medicine:

_____

_____

_____

_____

FAMILY HISTORY

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

_____

_____

_____

SOCIAL HISTORY

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

_____

_____

Alcohol - List any past or 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 pets? If yes, please list: _____

Recent travel outside of the country: _____

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 locations: _____

_____

_____

HEALTH MAINTENANCE HISTORY

List any specialists that you see on a regular basis. Please list name, address, 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? _____