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ADULT PATIENT INFORMATION

Today's Date: _____ Referring Doctor: _____

Patient's name: _____ Preferred or nickname: _____
(last name) (first name) (MI)

Patient: Age: _____ DOB: _____ Gender: M F Marital Status: M S D W

SS#: _____ Driver's License # : _____

Home Address: _____

City: _____ State: _____ ZIP: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Patient's Employer: _____ Occupation: _____

Business Phone: _____ EXT _____ Best time & Place to call _____

Spouse's Name: _____ Employer: _____

Occupation: _____ Business Phone: _____

Patient's primary care physician: _____

Emergency notification (other than spouse): _____

INSURANCE INFORMATION (we will copy your insurance card if you have it)

Name of Subscriber (if other than patient): _____ Relationship to patient: _____

Subscriber's birth date: _____ Subscriber's SS#: _____

Subscriber's Employer: _____ Subscriber's business phone #: _____

Insurance Company name: _____ Insurance Phone #: _____

ID#, Policy, or Recipient #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Name of Subscriber (if other than patient): _____ Relationship to patient: _____

Subscriber's birth date: _____ Subscriber's SS#: _____

Insurance Company name: _____ Insurance Phone #: _____

ID#, Policy, or Recipient #: _____ Group #: _____

As a courtesy to you, our staff will help you file your insurance forms. We do not charge you for performing these tasks and they are not part of the medical services we render to you. Accordingly, we cannot be responsible for errors of delay in filling out and/or submission of insurance forms.

Regardless of any insurance I may have, it is my responsibility to pay my bill. I hereby authorize my insurance company to pay Dr. Lyons directly for my care. I understand I am financially responsible for charges not covered by my insurance. Authorization to release my medical records for insurance purposes is granted by me.

SIGNATURE: _____ DATE: _____