HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION FORM
HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)	PREFERRED NAME	DATE OF BIRTH	SOC. SEC. NUMBER

SEX ASSIGNED AT BIRTH	SEX LISTED WITH HEALTH INSURANCE	WHAT IS YOUR GENDER IDENTITY?	PREFERRED PRONOUNS
❑ FEMALE ❑ MALE ❑ INTERSEX	❑ FEMALE ❑ MALE	❑ SAME AS SEX LISTED WITH INSURANCE ❑ OTHER:_____	❑She/Her ❑ Ze/Hir ❑He/His/Him

PERMANENT STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS ❑MYCHART ❑ DISCHARGE INSTRUCTIONS ❑ DECLINE

TEMPORARY ADDRESS (IF APPLICABLE)	CITY	STATE	ZIP CODE

GENERAL INFORMATION

HISPANIC ETHNICITY?	RACE	ADDITIONAL RACE	ETHNICITY
❑ YES ❑ NO ❑UNKNOWN ❑ DECLINE			

FURTHER DESCRIPTION OF ETHNICITY # 1	FURTHER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH
		❑ VERY WELL ❑ WELL ❑ NOT WELL ❑ NOT AT ALL ❑ DECLINED ❑ UNAVAILABLE

WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?	IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?

WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? ❑ YES ❑NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ❑ YES ❑ NO

MARITAL STATUS	VISUALLY IMPAIRED? ❑ YES ❑NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? ❑ YES ❑ NO	NOTIFY PCP OF RESULTS? ❑ ALL ❑ ABNORMAL ❑ NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		

PATIENT'S EMPLOYER	PATIENT OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT	RETIREMENT DATE

EMPLOYER ADDRESS (no., stret, city, state, zip code)	EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME CONTACT #1	ADDRESS (no., street, apt#, city, state, zip code)

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

FULL NAME CONTACT #2	ADDRESS

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION DOWNTIME FORM
HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The person responsible for the bill)

GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE
EMPLOYER		OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? ❑ YES ❑ NO	INJURED BODY PART: ❑ RIGHT ❑ LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

TERTIARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

WORKER'S COMPENSATION/NO FAULT INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER

New Patient Questionnaire

Orthopedic Sports Medicine and Shoulder

HOSPITAL FOR SPECIAL SURGERY

Name:	DOB:	Date:
Height:	Weight:	Age:

What is your dominant hand? ○ Right ○ Left ○ Ambidextrous

Chief Complaint

What is the reason for your visit? _____

_____

_____

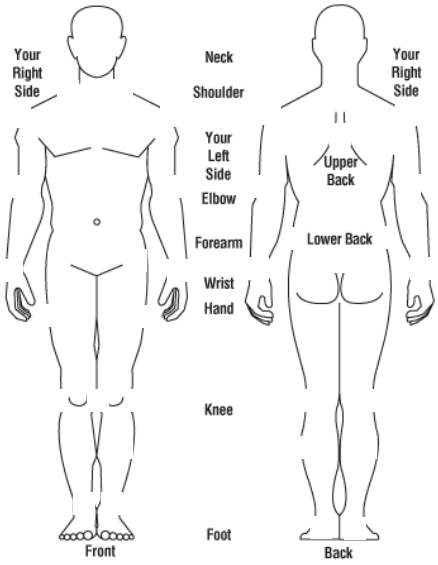
Please describe your symptoms:

☐ Swelling	☐ Stiffness	☐ Locking	☐ Instability
☐ Giving Away	☐ Numbness	☐ Weakness	☐ Tingling
☐ Catching	☐ Clicking	☐ Other:	

Current Pain Level (no pain 0 – 10 highest):

○ **0**	○ **1**	○ **2**	○ **3**	○ **4**	○ **5**	○ **6**	○ **7**	○ **8**	○ **9**	○ **10**

Please mark on the body diagram where you are experiencing pain:



When did this condition start? _____

Onset:	○ Gradual	○ Sudden	
Pain Frequency:	○ Constant	○ Intermittent	○ Rarely
Quality:	Sharp	Dull	Burning
	Tingling	Throbbing	Other
Night Pain:	○ Yes	○ No	
Swelling:	○ Yes	○ No	
Feels unstable/gives way:	○ Yes	○ No	
Range of Motion:	○ Normal	○ Decreased	

Everyday Activities:	○ No Restrictions	○ Limited	○ Unable
Recreational Activities:	○ No Restrictions	○ Limited	○ Unable

Does anything make the pain better? _____

Does anything make the pain worse? _____

Do you participate in any sports? _____

Level of play:	○ Professional	○ College	○ High School	○ Recreational

Have you had or tried any of the following (please select and describe)?

Type	Date Range	Location/Results	Effective?
☐ Acupuncture Treatment			◯ Yes ◯ No
☐ Anti-Inflammatory Medications			◯ Yes ◯ No
☐ Chiropractic Treatment			◯ Yes ◯ No
☐ Injections			◯ Yes ◯ No
☐ Physical Therapy			◯ Yes ◯ No
☐ Massage Therapy/Deep Tissue			◯ Yes ◯ No
☐ MRI			
☐ CT			
☐ X-Ray			

Referring Physician: _____ Phone Number: _____

Screening Questions (Coordination of Care)

Are you currently on any blood thinners? ◯ Yes ◯ No

Have you ever had a MRSA Infection? ◯ Yes ◯ No

Have you had Deep Vein Thrombosis (DVT)? ◯ Yes ◯ No

Have you had a Pulmonary Embolism (PE)? ◯ Yes ◯ No

Have you ever had any problems with anesthesia? ◯ Yes ◯ No Problem: _____

Have you ever had complications from prior surgery? ◯ Yes ◯ No Problem: _____

Have you had surgery for this same condition before? ◯ Yes ◯ No

Do you have any of the following medical devices? (Mark all that apply)

☐ Pain Pump	☐ Neurostimulator	☐ Pacemaker and/or Defibrillator	☐ Shunt for hydrocephalus

Do you have diabetes? ◯ Yes ◯ No

If yes, do you have an insulin pump? ◯ Yes ◯ No

Have you been taking opioids for 6 months or more (e.g. codeine, percocet, morphine, Vicodin, etc.)? ◯ Yes ◯ No

For Females Only: Gynecological History

Do you think you may be pregnant at this time?	◯ Yes ◯ No	Date:
Do you use birth control?	◯ Yes ◯ No	Type:
Have you experienced menopause?	◯ Yes ◯ No	When:
Have you had a hysterectomy?	◯ Yes ◯ No	When:
Last pap smear:	Date:	
Last mammogram:	Date:	
Age you began your first period:		
When was your most recent menstrual period?	Date:	
How many periods have you had during the last 12 months?		
Number of pregnancies:		

Please list any allergies below (including medications, foods, and environment):

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Medical and Family History

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	Yourself?	Family Member?	Condition	Yourself?	Family Member?
☐ Anxiety	☐ Yes	☐ Yes	☐ Open Wounds/Ulcers	☐ Yes	☐ Yes
☐ Arrhythmia (Irregular heartbeat)	☐ Yes	☐ Yes	☐ Osteoarthritis	☐ Yes	☐ Yes
☐ Asthma	☐ Yes	☐ Yes	☐ Osteoporosis	☐ Yes	☐ Yes
☐ Bleeding Problems	☐ Yes	☐ Yes	☐ Peripheral Vascular Disease	☐ Yes	☐ Yes
☐ Blood Clots (DVT)	☐ Yes	☐ Yes	☐ Pneumonia	☐ Yes	☐ Yes
☐ Cancer	☐ Yes	☐ Yes	☐ Psychiatric Illness (Depression)	☐ Yes	☐ Yes
☐ Diabetes	☐ Yes	☐ Yes	☐ Pulmonary Embolus	☐ Yes	☐ Yes
☐ Heart Attack	☐ Yes	☐ Yes	☐ Reflex Sympathetic Dystrophy	☐ Yes	☐ Yes
☐ Heart Disease	☐ Yes	☐ Yes	☐ Reflux	☐ Yes	☐ Yes
☐ High Blood Pressure	☐ Yes	☐ Yes	☐ Rheumatoid Arthritis	☐ Yes	☐ Yes
☐ High Cholesterol	☐ Yes	☐ Yes	☐ Seizures	☐ Yes	☐ Yes
☐ Infection	☐ Yes	☐ Yes	☐ Stroke	☐ Yes	☐ Yes
☐ Kidney Disorders	☐ Yes	☐ Yes	☐ Ulcers	☐ Yes	☐ Yes
☐ Lung Disease	☐ Yes	☐ Yes	☐ Other:	☐ Yes	☐ Yes

Please list the family member (father, mother, etc.) to any of the positive responses you listed above:

_____

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

Social History

Are you a tobacco user? ○ Yes ○ No

Do you consume alcohol? ○ Yes ○ No

If yes, how many drinks per week? _____

Occupation: _____ Employer: _____

Immunizations and Falls Screening:

Have you received the pneumonia vaccine? ○ Yes ○ No

If yes, date? _____ If not, why? _____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? ○ Yes ○ No

If yes, date? _____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? ○ Yes ○ No

If yes, do you have vision problems that may have contributed to your fall? ○ Yes ○ No

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
☐ Activity Change	☐ Congestion	☐ Dryness	☐ Chest tightness
☐ Appetite Change	☐ Ear pain	☐ Discharge	☐ Choking
☐ Chills	☐ Nosebleeds	☐ Itching	☐ Cough
☐ Fatigue	☐ Sinus pressure	☐ Pain	☐ Shortness of breath
☐ Fever	☐ Sore throat	☐ Redness	☐ Wheezing
☐ Weight Change			
☐ None	☐ None	☐ None	☐ None

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
☐ Chest pain	☐ Abdominal pain	☐ Cold intolerance	☐ Difficult urination
☐ Leg swelling	☐ Blood in stool	☐ Heat intolerance	☐ Flank pain
☐ Palpitations	☐ Constipation	☐ Excessive thirst	☐ Frequent urination
☐ Poor circulation	☐ Heartburn	☐ Excessive hunger	☐ Painful urination
	☐ Nausea		
☐ None	☐ None	☐ None	☐ None

Musculoskeletal	Skin	Environmental Allergies	Neurological
☐ Joint pain	☐ Color change	☐ Pollen	☐ Dizziness
☐ Joint stiffness	☐ Hair loss	☐ Dust Mites	☐ Headaches
☐ Joint swelling	☐ Rash	☐ Pets/Animals	☐ Light-headedness
☐ Joint warmth/heat	☐ Skin tightening	☐ Mold/Mildew	☐ Memory loss
☐ Muscle pain	☐ Wound	☐	☐ Numbness
☐	☐	☐	☐ Weakness
☐ None	☐ None	☐ None	☐ None

Hematologic	Psychiatric	Other
☐ Enlarged lymph nodes	☐ Agitation	
☐ Bruises	☐ Hyperactive	
☐ Clotting problem	☐ Nervous/anxious	
☐ Excessive bleeding	☐ Depression	
☐ None	☐ None	

Ranawat Orthopedics HSS

- ❒ Chitranjan S. Ranawat, M.D.
- ❒ Amar S. Ranawat, M.D.
- ❒ Anil S. Ranawat, M.D.

Financial Interest Disclosure Form
Medical Staff, Allied Health Professional Staff,
Residents, and Fellows

As your treating physician(s) and as a member(s) of the Medical Staff of Hospital for Special Surgery (HSS), we would like you to know that we have several financial relationships with orthopedic device companies whose products we may use in your care at HSS. The following will provide you with information about our current financial relationships for Ranawat Orthopedics HSS:

Dr. Amar Ranawat:
Dr. Amar Ranawat is a consultant for Ceramtec, LTD, Convatec and DePuy Orthopedics, Inc. Dr. Ranawat also receives research support from Ceramtec, LTD.

Dr. Anil Ranawat:
Dr. Anil Ranawat is a consultant on the unicompartmental knee team for Stryker - MAKO Surgical Corp. Dr. Ranawat is Editor-in-Chief for which receives salary support from Springer, and receives royalties from Elsevier, Inc.

Dr. Chitranjan Ranawat:
Dr. Chitranjan Ranawat is a consultant and product designer for DePuy Orthopedics, Inc. on the Sigma® and Attune™ total knee prosthesis systems for which he receives royalty payments.

WE DO NOT RECEIVE ANY PAYMENTS FROM THESE COMPANIES FOR USE OF THEIR PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with us, you may either contact the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship disclosed to you, you choose to refuse a particular treatment, operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that you understand the financial interest or relationship described above. You also confirm that you have the right to ask any questions to your providing physician.

Signature_____
Patient/Parent/Guardian/Health Care Agent **Date**

Print Name_____
Patient/Parent/Guardian/Health Care Agent

_____
Relationship to Patient

PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD

For Office Use Only: If the patient does not sign this acknowledgment form, record here the good faith efforts made to obtain this acknowledgement.

_____
_____
_____