

**Hospital for Special Surgery
Rehabilitation Department**

Patient Registration Form

*Print your FULL NAME as it appears on Legal ID (Driver's License/State ID/Passport).
If it differs from your insurance card, please inform the front desk.*

FULL NAME (Last, first, middle initial)		DATE OF BIRTH (D.O.B.)	HSS# <small>(OFFICE USE ONLY)</small>
HOME ADDRESS		CITY, STATE & ZIP CODE	
SSN# (OPTIONAL)	SEX	MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
HOME PHONE	WORK PHONE	CELL/OTHER	

Employment Information (If full-time student provide information on school)

EMPLOYER	OCCUPATION	<input type="checkbox"/> Full time <input type="checkbox"/> Retired (DATE: ___/___/___) <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Unemployed
EMPLOYER ADDRESS (Number, street, city, state, zip code)		EMPLOYER PHONE

Guarantor/Policy Holder (The person responsible for the bill)

FULL NAME (Last, first, middle initial)	RELATIONSHIP TO PATIENT	D.O.B.	SEX	SSN	HOME ADDRESS
EMPLOYER NAME	EMPLOYER ADDRESS	OCCUPATION	<input type="checkbox"/> Full time <input type="checkbox"/> Retired (DATE: ___/___/___) <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Unemployed		

Insurance Information (If No-Fault or Worker's comp please complete accident information)

PRIMARY INSURANCE COMPANY NAME		POLICY/ID/CLAIM#	GROUP/CASE#	
ADDRESS		POLICY HOLDER	POLICY HOLDER D.O.B.	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE COMPANY NAME		POLICY/ID/CLAIM#	GROUP/CASE#	
ADDRESS		POLICY HOLDER	POLICY HOLDER D.O.B.	RELATIONSHIP TO PATIENT
ACCIDENT <input type="checkbox"/> Yes <input type="checkbox"/> No	ACCIDENT TYPE <input type="checkbox"/> Vehicle <input type="checkbox"/> Employment <input type="checkbox"/> Other	ACCIDENT ID#	ACCIDENT DATE & TIME	

Referring Physician

PHYSICIAN NAME	ADDRESS	PHONE
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Relative Information

NAME OF RELATIVE/SPOUSE	ADDRESS & PHONE	RELATIONSHIP TO PATIENT	D.O.B.
EMPLOYER	EMPLOYER ADDRESS & PHONE	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Student <input type="checkbox"/> Retired (Date: ___/___/___)	

ASSIGNMENT & RELEASE OF INFORMATION STATEMENT – I certify that the information given by me above is correct. I understand that this information is entered into a database and I hereby authorize the sharing of such information with Hospital-affiliated physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care, as requested by government agencies and/or insurance carriers for processing of claims. I hereby assign benefits to the Hospital and understand that in the absence of coverage, I (or my legal guardian) am responsible for full payment for services rendered.

MEDICARE PATIENTS – I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductible on all services; 20% co-insurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow payment under Hospital policies.

EFFECTIVE DATE – These statements shall be effective from the date of the signature of the below until December 31 of the current year, unless Hospital for Special Surgery is notified otherwise in writing at the address listed above.

CONSENT- I consent to the services provided to me at Hospital for Special Surgery ICC (an affiliate of Hospital for Special Surgery)

Patient Or Guardian Signature:

Today's Date: