# PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY
535 East 70th Street NEW YORK, NY 10021

MEDICAL RECORD NUMBER **(FOR OFFICE USE ONLY)**

DATE OF VISIT

LEGAL ID TYPE ❑ DRIVER'S LIC. ❑ PASSPORT ❑ BIRTH CERT. ❑ SSN ❑ GREEN CARD ❑ OTHER

HOSPITAL PHYSICIAN

PATIENT'S FULL NAME (Last, First, MI.) | DATE OF BIRTH | BIRTH PLACE

STREET ADDRESS | CITY | STATE | ZIP CODE

COUNTRY | HOME PHONE | SEX | RACE | MARITAL STATUS | SOC. SEC. NUMBER | CELL PHONE (if applicable)

TEMPORARY ADDRESS #1 | E - MAIL ADDRESS

ARE YOU CURRENTLY RESIDING IN A SKILLED NURSING FACILITY OR INPATIENT REHAB FACILITY? ❑ YES ❑ NO | IF YES, PROVIDE NAME OF FACILITY

SKILLED NURSING FACILITY/REHAB FACILITY ADDRESS | PHONE NUMBER OF FACILITY

HAVE YOU EVER BEEN TO HSS FOR A DOCTOR OR HOSPITAL VISIT ? ❑ YES ❑ NO | IF SO, WHAT DOCTOR AND WHEN WERE YOU SEEN?

## EMPLOYMENT (If full-time student provide information on school)

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

EMPLOYER ADDRESS (no., stret, city, state, zip code) | EMP PHONE | E - MAIL ADDRESS

## GUARANTOR (The person responsible for the bill)

❑ SELF ❑ SPOUSE ❑ PARENT/GUARDIAN ❑ OTHER ( If guarantor other than self, provide person's information below)

## EMERGENCY CONTACT

PERSON # 1 FULL NAME (Complete this section for Spouse, Parent, Legal Guardian, etc.) | RELATIONSHIP TO PATIENT | DATE OF BIRTH

ADDRESS (no., street, apt#, city, state, zip code) | SEX | HOME PHONE | SOC. SEC. NUMBER

EMPLOYER | OCCUPATION | ❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT | RETIREMENT DATE

EMPLOYER ADDRESS (no., street, city, state, zip code) | EMP PHONE

PERSON # 2 FULL NAME | RELATIONSHIP TO PATIENT | DATE OF BIRTH

ADDRESS (no., street, apt#, city, state, zip code) | SEX | HOME/WORK/CELL PHONE

## MEDICAL DETAIL

REASON FOR VISIT OR CHIEF COMPLAINT | ALLERGIES

IF YOUR SERVICE IS RELATED TO AN INJURY OR ACCIDENT - HOW DID YOUR INJURY OCCUR?

DATE OF INJURY | TIME OF INJURY | PLACE OF INJURY

REFERRING PHYSICIAN & ADDRESS

## PRIMARY INSURANCE

INSURANCE COMPANY NAME | PHONE NUMBER

INSURANCE COMPANY ADDRESS | NAME OF CLAIMS ADJUSTER (if applicable)

POLICY NUMBER | GROUP/PLAN NUMBER | CLAIM NUMBER (if applicable) | WCB CASE NUMBER (if applicable)

## SECONDARY INSURANCE

INSURANCE COMPANY NAME | PHONE NUMBER

INSURANCE COMPANY ADDRESS | POLICY NUMBER | GROUP/PLAN NUMBER

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT - I certify that the information given by me 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. I hereby assign benefits to the Hospital and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of 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 deductibles on all services and a 20% co-insurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow payment terms under Hospital policies.

EFFECTIVE DATE - These statements shall be effective from the date of the signature below until December 31 of the current year, unless you notify HSS otherwise in writing at the address written above.

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____