

ELIZABETH M. MANEJÍAS, M.D.
REGISTRATION FORM

DATE: _____ **HSS#** _____

PATIENT'S FULL NAME: _____

DATE OF BIRTH: _____ **SSN** _____ **M / F**

MARITAL STATUS: S / M / D / W (PLEASE SELECT ONE)

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **OFFICE:** _____ **Ext:** _____

EMAIL: _____ **CELL:** _____

NAME OF EMERGENCY CONTACT / RELATION: _____

ADDRESS: _____ **PH#** _____

NAME OF LEGAL GUARDIAN (if under 18 yrs): _____

CONTACT INFO: _____

PRIMARY INSURANCE: _____ **POLICY #** _____

GUARANTOR NAME: _____ (Insurance Policy holder)

RELATIONSHIP TO PATIENT: _____ **DOB:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMPLOYER: _____ **OCCUPATION:** _____

PRIMARY CARE DOCTOR: _____

TEL: _____ **FAX:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

REFERRING DOCTOR or SOURCE: _____

TEL: _____ **FAX:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

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 release of information related to my medical care as requested by government agencies and/or insurance carriers. I hereby assign benefits and understand that in the absence of accepted insurance coverage, I/Legal guardian am responsible for full payment of services rendered.

Medicare Patient: I understand that I am responsible for insurance deductibles on all services, 20% co-insurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow payment terms under your policies.

Litigation Disclaimer: It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not requesting any information in connection with pending or proposed litigation.

Authorized Signature/Guardian: _____ **Date:** _____



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 Hospital for Special Surgery

New Patient Questionnaire

Name _____ Age _____ Birthdate _____

Referred by (first and last name) _____

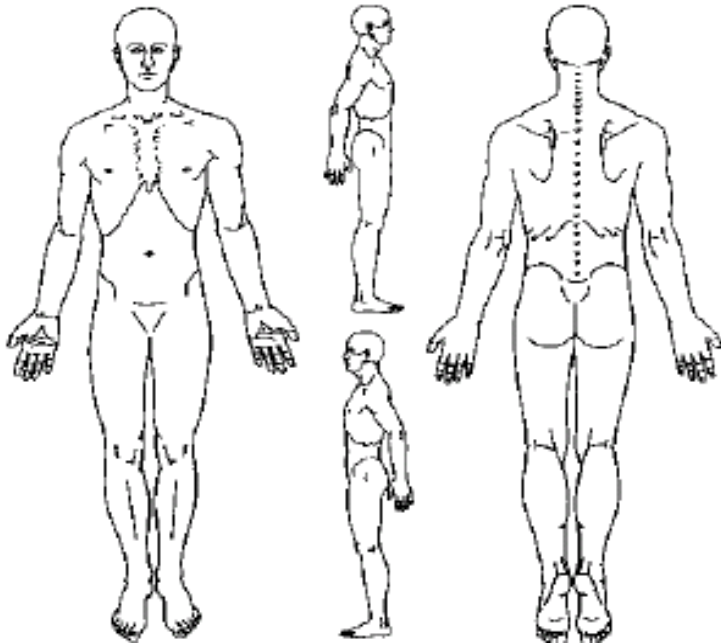
Chief Complaint _____

Date of injury or symptom onset: _____

Please describe the injury or problem: _____

Front

Back



Where is your pain? Please mark the drawing.

Rate Your Pain:

0 = No pain 10 = Extreme pain

Please indicate your pain level

No Pain to Worst Pain

1. Right now 0 1 2 3 4 5 6 7 8 9 10

2. At best 0 1 2 3 4 5 6 7 8 9 10

3. At worst 0 1 2 3 4 5 6 7 8 9 10

4. What make it better? _____

5. What makes it worse? _____

Circle the words which best describe your symptoms:

Dull/Ache
Numbness

Shooting
Throbbing

Awareness
Heaviness

Sharp/Stabbing
Weakness

Gnawing
Tightening/Constricting

Burning

What diagnostic tests have you had for this condition? (X-ray, MRI, EMG etc.) Date?

Please list all treatments that you have tried for your condition including physical/occupational therapy, massage, acupuncture, chiropractor, injections, and medications (please list type of injection and/or medications).

Circle which treatments have helped you the most.

Your Medical History

Please list any ongoing medical problems (High blood pressure, Diabetes, Thyroid disorder, Cancer, Bleeding disorder, Heart disorder, Asthma, Arthritis, Headaches)

Past Surgical History _____

Current Medications, Vitamins, or Nutritional Supplements _____

Are you allergic to any medication? Y N If yes, please list _____

Gynecological History (if applicable)

Date of last menstrual period: _____ Age you began menstruating: _____

Have you experience menopause/hysterectomy? Y N If yes, when _____

How many periods have you had in the last 12 months? _____

Do you use birth control? Y N If yes, what type _____

Family History

Does anyone in your family have any of the following problems?

Heart disease High blood pressure Cancer Nerve problems Stroke Diabetes Blood
problems Other _____

Please Circle Current Symptoms or Problems

recent weight change dizziness loss of bowel control change in urinary habits fatigue
seizures muscle weakness visual changes constipation fever/chills chest pain
nausea/vomiting night pain headaches shortness of breath numbness
joint stiffness, pain or swelling depressed mood memory loss skin rash/disease

Are you under any emotional stress or suffer from anxiety or depression? If yes are you undergoing any treatment? _____

What is your occupation or former occupation? Are you retired or disabled?

Are you single, married, divorced, or a widow/widower? _____

Who lives within your household? _____

What type of physical activity do you do and for how many hours per week?

Do you smoke, drink alcohol, or use illegal substances? If yes, how often?

Do you consider your current weight ideal? Y N If not, what is your ideal weight? _____

Do you have any questions about healthy ways to control your weight? _____

What are your goals or expectations from our treatment? _____

What specific issues would you like addressed today? _____

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Last Name: _____ First Name _____

Address _____ City _____ State _____ Zip _____

Sex: _____ SS# _____ D.O.B. _____

Telephone (H) _____ (W) _____ (C) _____

Emergency contact _____ relation: _____

X-rays within 3-6 months _____ Location _____

Workers Compensation Information:

Case Manager: _____ Phone _____

Insurance Carrier _____ Claim #: _____

Address: _____ City _____ State _____ Zip _____

Date of injury: _____ Address where injury occurred: _____

City _____ State _____ Zip _____ Time: _____

No Fault Insurance Information

Name of Vehicle Ins. Company: _____

Address _____ City: _____ State _____ Zip _____

Name of Adjuster: _____ Phone _____

Policy #: _____ Claim #: _____

Date of Accident: _____ Injury: _____