

PATIENT REGISTRATION FORM

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

MEDICAL RECORD NUMBER

DATE OF VISIT

HOSPITAL PHYSICIAN

PATIENT'S FULL NAME (last, first, MI.)

DATE OF BIRTH

BIRTH PLACE

ADDRESS (no., street, apt#, city, state, zip code)

COUNTY

HOME PHONE

SEX

RACE

MARITAL STATUS

SOC. SEC. NUMBER

RELIGION

TEMPORARY ADDRESS #1

CELL PHONE (if applicable)

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., street, 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)

RELATIVES (Persons to be notified in case of emergency)

RELATIVE # 1 FULL NAME

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

RELATIVE # 2 FULL NAME

RELATIONSHIP TO PATIENT

DATE OF BIRTH

ADDRESS (no., street, apt#, city, state, zip code)

SEX

HOME PHONE

MEDICAL DETAIL

COMPLAINT

ALLERGIES

REF. PHYSICIAN/ ADDRESS

PRIMARY INSURANCE: ■ MEDICAID ■ MEDICARE ■ BLUE CROSS ■ COMMERCIAL ■ WORKMEN'S COMP ■ NO-FAULT

INSURANCE COMPANY NAME

POLICY NUMBER

INSURANCE COMPANY ADDRESS

PHONE NUMBER

ACCIDENT DATE

ACCIDENT TIME

ACCIDENT PLACE

CLAIM NUMBER

WCB CASE NUMBER

NATURE OF ACCIDENT

SECONDARY INSURANCE: ■ MEDICAID ■ MEDICARE ■ BLUE CROSS ■ COMMERCIAL ■ WORKMEN'S COMP ■ NO-FAULT

INSURANCE COMPANY NAME

POLICY NUMBER

INSURANCE COMPANY ADDRESS

PHONE NUMBER

ACCIDENT DATE

ACCIDENT TIME

ACCIDENT PLACE

CLAIM NUMBER

WCB CASE NUMBER

NATURE OF ACCIDENT

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, 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 _____

Frank A. Cordasco, MD PLLC
WELCOME TO OUR OFFICE

We appreciate your cooperation in filling out this form. Please give the Secretary your insurance card to copy for our records.

TODAY'S DATE _____

PATIENT INFORMATION

Patient's name: _____ Male ___ Female ___

Date of Birth: _____ Age: _____

REFERRAL SOURCE

Is this a second surgical opinion? _____ Referred by friend: _____

Referring Physician: _____

Address: _____ Phone: _____

PATIENT MEDICAL HISTORY

Please note the reason for today's visit: _____

I am Right Handed _____ I am Left Handed _____

ALLERGIES: _____

CURRENT MEDICAL CONDITIONS: _____

CURRENT MEDICATIONS: _____

List prior surgeries of any kind including dates and complications: _____

Please provide any additional medical information relevant to your current problem:

SLEEP APNEA Yes or No **CARDIAC STENT** Yes or No

ARE YOU TAKING PLAVIX OR ANY OTHER ANTI-COAGULANTS? Yes or No

Turn page over...

INSURANCE/PAYMENT ISSUES

We are committed to providing you with the best possible service. If you have insurance, we will help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our policies. You should be knowledgeable of your health insurance benefits. Do not assume that we know what your benefits are. Your insurance contract is between you and the insurance company. All services/supplies deemed NON COVERED as noted in your carrier coverage manual are the sole financial responsibility of the patient. Unless your contract is in network with our office, any charges that are above the Reasonable and Customary rate are also the sole responsibility of the patient. Payment/co-payment for services is due at the time services are rendered. Upon payment we will help you process your insurance claim for your reimbursement. If your carrier requires a REFERRAL, one must be presented at the time of service or full payment must be made at time of service.

PATIENT AUTHORIZATIONS

Claims Authorization

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s).

I **also** authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until it's final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.

Assignment of Benefits – Private and Federal

I authorize payments of medical and surgical benefits to be made either to me or on my behalf to this office for any services furnished by my physician to me. I understand that any services deemed "Non Covered" by my carrier are my sole financial responsibility, as outlined in my coverage manual. Prompt and complete payment of said services is also my sole responsibility.

Litigation Disclaimer

It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical record in the possession and control of this office, pursuant to receipt of a properly notarized consent for medical information requested by the patient or his/her legal guardian and upon payment of the usual fee.

Patient/Guardian

Signature: _____ **Date:** _____

Guardian name printed _____