

PATIENT REGISTRATION FORM HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DE										
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 ☐ FEMALE			THEALTH INSONAINCE	TED WITH INSURAN	ICE	PREFERENCE PROPOSITION				
☐ MALE ☐ MALE							□She/Her □ Ze/Hir □He/His/Him			
☐ INTERSEX				OTHER:						
PERMANENT ST	REET ADDRES	iS			CITY		STATE	ZIP CODE		
			1							
COUNTRY HOME PHONE CELL PHONE			CELL PHONE	E - MAIL ADDRESS ☐M			YCHART DISCHARGE INSTRUCTIONS DECLINE			
TEMPORARY ADDRESS (IF APPLICABLE)					CITY		STATE	ZIP CODE		
	·	•								
GENERAL IN	IFORMATI	ON								
HISPANIC ETHNIC	ITY?			RACE		ACE	ETHNICITY			
		D DECLINE								
☐ YES ☐ NO FURTHER DESCRI			FURTUER DESCRIPTION	OF FTUNICITY # 2	DATE VOLID AS	ULITY TO CDEAK	AND UNDERSTAND ENGLISH			
FURTHER DESCRI	PTION OF ETHI	NICITY#1	FURTHER DESCRIPTION	OF ETHNICITY # 2		RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH VERY WELL WELL NOT WELL NOT AT ALL DECLINED				
					☐ UNAVAILA		NOT WELL & NOTATALL & DECLINED			
WHAT IS YOUR P	REFERRED SPO	KEN LANGUAGE FO	R HEALTH CARE INSTRUC	TIONS?	IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?					
			T							
WOULD YOU LIKE CHARGE?	AN INTERPRE	TER FREE OF	RELIGION			WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY?				
CHARGE? ☐ YES	□NO)			☐ YES	☐ NO				
MARITAL STATUS		VISUALLY IMPAIR	ED?	PLEASE LIST ANY VISU	JAL OR HEARING NI	EDS				
		☐ YES	□NO							
DATIENT CO	NITACTO									
PATIENT CC			PCP TELEPHONE NUMB	ED.	NOTIFY PCP OF	ADMISSIONIS	NOTIFY PCP OF RESULTS?			
PRIMARY CARE PROVIDER (PCP) PCP TELEPHON			PCP TELEPHONE NOIVIB	DEN	☐ YES	□ NO	□ ALL □ ABNO	ORMAL • NONE		
							_ / /			
REFERRING PROVIDER REF			REFERRING PROVIDER	TELEPHONE						
PATIENT'S EMPLOYER			PATIENT OCCUPATION			☐ FULL-TIM	E 📮 PART-TIME	RETIREMENT DATE		
EMBLOVED ADDR	ESS (no. strat	city, state, zip code	<u> </u>			☐ RETIRED	STUDENT EMPLOYER PHONE			
LIVIPLOTEN ADDIN	L33 (110., 3ti et,	city, state, zip code	-1				LIVIFLOTER FITONE			
EMERGENC	Y CONTAC	T								
FULL NAME CON	TACT #1			ADDRESS (no., street	t, apt#, city, state, z	ip code)				
				·						
HOME PHONE WORK NUMBE		WORK NUMBER		CELL PHONE	RELATIONSHIP	TO PATIENT	LEGAL GUARDIAN?	SUPPORT PERSON?		
							□YES □ NO	☐ YES ☐ NO		
ELILI NANAE CONT	TACT #2			ADDRESS						
FULL NAME CONTACT #2			ADDRESS							
HOME PHONE W		WORK NUMBER		CELL PHONE	RELATIONSHIP	TO PATIENT	LEGAL GUARDIAN?	SUPPORT PERSON?		
							□YES □ NO	☐ YES ☐ NO		
I		1								



PATIENT REGISTRATION DOWNTIME FORM HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The per	son responsi	ble for the bill)						
GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)					
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUM	BER	HOME PHON	NE	CELL PHONE	
EMPLOYER		OCCUPATION				MAE DADT TIME	RETIREMENT DATE	
			☐ FULL-TI					
EMPLOYER ADDRESS (no., stre	et city state zin	code)			☐ RETIRE	D STUDENT	EMP PHONE	
ENT ESTERABBILESS (No., stre	ec, city, state, zip	code,					EIVII TTIONE	
VISIT INFORMATION								
VISIT INFORMATION VISIT RELATED TO AN ACCIDENT	OR INITIRY?	INJURED BODY PART:	☐ RIGHT ☐ LEFT	HOW DID YOU	IR INILIRY OCC	IIR?		
VISIT RELATED TO AN ACCIDENT OR INJURY?			a morri	NOW DID 100	KINGKI OCCOK:			
DATE OF INJURY		TIME OF INJURY		PLACE OF INJU	IRY			
DATE OF HUSEKI	FLACE OF INJUNT							
INSURANCE INFORMA	TION							
PRIMARY INSURANCE	TION							
SUBSCRIBER NAME			RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER	
					JLX	DATE OF BIRTH	EIVII 20 TEIX	
INSURANCE COMPANY NAME					PHONE NUN	 1BER		
						.52.1		
INSURANCE COMPANY ADDRE	SS			NAME OF CLAIMS ADJUSTER (if ap		AIMS ADJUSTER (if applicable)		
						(),,,		
POLICY NUMBER		GROUP/PLAN NUMBE	R CLAIM NUME		BER (if applicable)		CASE NUMBER	
		,			` ''	,		
SECONDARY INSURANCE								
SUBSCRIBER NAME			RELATIONSHIP TO PATI	ENT	SEX	DATE OF BIRTH	EMPLOYER	
INSURANCE COMPANY NAME					PHONE NUM	IRFR		
						.52.1		
INSURANCE COMPANY ADDRE	cc				POLICY NUM	IDED	GROUP/PLAN NUMBER	
INSURANCE COMPANY ADDRE	:55				POLICY NOW	IBEK	GROUP/PLAN NUIVIBER	
TERTIARY INSURANCE			DEL ATIONICIUS TO DATI	ENIT	CEV	DATE OF DIDTH	EMPLOYED.	
SUBSCRIBER NAME			RELATIONSHIP TO PATI	EINI	SEX	DATE OF BIRTH	EMPLOYER	
INSURANCE COMPANY NAME					PHONE NUN	MDED		
INSURANCE COMPANY NAME					PHONE NON	IDEN		
INSURANCE COMPANY ADDRE	SS				POLICY NUM	1BER	GROUP/PLAN NUMBER	
WORKER'S COMPENSATION/N	IO FAULT INSURA	NCE						
SUBSCRIBER NAME	RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER			
INSURANCE COMPANY NAME				PHONE NUMBER				
INSURANCE COMPANY ADDRE	SS			NAME OF CLAIMS ADJUSTER (if applicable)				
POLICY NUMBER GROUP/F		GROUP/PLAN NUMBE	AN NUMBER CLAIM NU		BER (if applica	ble)	CASE NUMBER	