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

HOSPITAL PHYSICIAN

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

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	

PHYSICIAN INFORMATION

REFERRING PHYSICIAN & ADDRESS	OTHER PHYSICIAN INFORMATION

ACCIDENT RELATED INFORMATION

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

DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION (IF RELATED TO WORKER'S COMP OR NO FAULT, PLEASE ENTER WC OR NF IN PRIMARY INS. SPACE BELOW, AND ENTER HEALTH/MEDICAL COVERAGE IN SECONDARY INS. SPACE BELOW)

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 ____________