

PATIENT REGISTRATION FORM							
Center for Hip Preservation 541 East 71st Street, New York, NY 10021 Hospital for Special Surgery					MEDICAL RECORD NUMBER (FOR OFFICE USE ONLY)		
					DATE OF VISIT		
LEGAL ID TYPE <input type="checkbox"/> DRIVER'S LIC. <input type="checkbox"/> PASSPORT <input type="checkbox"/> BIRTH CERT. <input type="checkbox"/> SSN <input type="checkbox"/> GREEN CARD <input type="checkbox"/> OTHER					HOSPITAL PHYSICIAN Ernest L. Sink, MD		
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		
PRIMARY PHYSICIAN/ PEDIATRICIAN NAME & ADDRESS					PHYSICIAN PHONE #		
PHARMACY NAME/ ADDRESS					PHARMACY PHONE #		
HAVE YOU EVER BEEN TO HSS FOR A DOCTOR OR HOSPITAL VISIT ? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF SO, WHAT DOCTOR AND WHEN WERE YOU SEEN?			
EMPLOYMENT (If full-time student provide information on school)							
PATIENT'S EMPLOYER			PATIENT OCCUPATION		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	RETIREMENT DATE	
					<input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT		
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE	E - MAIL ADDRESS	
GUARANTOR (The person responsible for the bill)							
<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT/GUARDIAN <input type="checkbox"/> 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		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	RETIREMENT DATE		
				<input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT			
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 SUBSCRIBER (IF OTHER THAN PATIENT)		
POLICY NUMBER		GROUP/PLAN NUMBER		PATIENT'S RELATIONSHIP TO INSURED		SUBSCRIBER'S SOCIAL SECURITY #	
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 _____	