

PATIENT REGISTRATION FORM HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DI	EMOGRAPI	HICS								
NAME (AS LISTED ON IDENTIFICATION)				PREFERRED NAME			DATE OF BIRTH	SOC. SEC. NUMBER		
SEX ASSIGNED AT BIRTH Great FEMALE MALE MALE INTERSEX		I HEALTH INSURANCE	☐ SAME AS SEX LIST	NT IS YOUR GENDER IDENTITY? SAME AS SEX LISTED WITH INSURANCE OTHER:		PREFERRED PRONOUNS □She/Her □ Ze/Hir □He/His/Him				
PERMANENT STREET ADDRESS					CITY		STATE	ZIP CODE		
COUNTRY HOME PHONE			CELL PHONE		E - MAIL ADD	RESS DMY	☐ DISCHARGE INST	GE INSTRUCTIONS DECLINE		
TEMPORARY ADDRESS (IF APPLICABLE)					CITY		STATE	ZIP CODE		
GENERAL II	NFORMATI	ON								
HISPANIC ETHNI		☐ DECLINE		RACE	ADDITIONAL R	ACE				
FURTHER DESCRIPTION OF ETHNICITY # 1			FURTHER DESCRIPTION OF ETHNICITY # 2		☐ VERY WELL	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH VERY WELL WELL NOT WELL NOT AT ALL DECLINED UNAVAILABLE				
WHAT IS YOUR P	PREFERRED SPO	KEN LANGUAGE FO	R HEALTH CARE INSTRUC	TIONS?	IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?					
WOULD YOU LIKE AN INTERPRETER FREE OF RELIGION CHARGE?					WOULD YOU L	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ☐ YES ☐ NO				
	☐ YES ☐ NO VISUALLY IMPAIRED? ☐ YES ☐ NO			PLEASE LIST ANY VISUAL OR HEARING NEEDS						
PATIENT CO	ONTACTS									
PRIMARY CARE PROVIDER (PCP)			PCP TELEPHONE NUMBER		NOTIFY PCP OF	ADMISSION?	NOTIFY PCP OF RESULTS?	NORMAL 🔲 NONE		
REFERRING PROVIDER		REFERRING PROVIDER TELEPHONE								
PATIENT'S EMPL	PATIENT'S EMPLOYER		PATIENT OCCUPATION			FULL-TIME PART-TIME		RETIREMENT DATE		
EMPLOYER ADDI	RESS (no., street	t, city, state, zip cod	e)			□ RETIRED	STUDENT EMPLOYER PHONE			
EMERGENC				ADDRESS (no., street	ant# city state =	n code)				
FULL NAIVIE CON	JLL NAME CONTACT #1				, api#, city, state, zi	p code)				
HOME PHONE	PHONE WORK NUMBER		CELL PHONE	RELATIONSHIP	TO PATIENT	LEGAL GUARDIAN? □YES □ NO	SUPPORT PERSON? YES NO			
FULL NAME CONTACT #2				ADDRESS	•		•	1		
HOME PHONE WORK NUMBER			CELL PHONE	RELATIONSHIP	TO PATIENT	LEGAL GUARDIAN? YES NO	SUPPORT PERSON?			
PHARMAC NAME:										
ADDRESS:				_						
PHONE NU				_ FAX	FAX NUMBER:					



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GUARANTOR (The per	rson responsi	ble for the bill)							
GUARANTOR FULL NAME	•	, , , , , , , , , , , , , , , , , , ,	ADDRESS (no., street, apt#, city, state, zip code)						
	, , ,		, , ,						
	I	las.			l	_			
RELATIONSHIP TO PATIENT DATE OF BIRTH		SEX	SOCIAL SECURITY NUMBER		HOME PHON	E	CELL PHONE		
EMPLOYER	•	OCCUPATION	I.		☐ FULL-TII	ME PART-TIME	RETIREMENT DATE		
ENABLOYED ADDRESS /					☐ RETIRED	STUDENT	ELAB BUIGNE		
EMPLOYER ADDRESS (no., stre	eet, city, state, zip	code)					EMP PHONE		
VISIT INFORMATION									
VISIT RELATED TO AN ACCIDENT	OR INJURY?	INJURED BODY PART:	☐ RIGHT ☐ LEFT	HOW DID YOU	R INJURY OCCU	JR?			
☐ YES ☐ NO									
DATE OF INJURY	TIME OF INJURY		PLACE OF INJU	JRY					
DATE OF INJUNY			PLACE OF INJUNT						
INSURANCE INFORMA	TION								
PRIMARY INSURANCE									
SUBSCRIBER NAME			RELATIONSHIP TO PATI	ENT	SEX	DATE OF BIRTH	EMPLOYER		
INSURANCE COMPANY NAME			l .		PHONE NUM	BER			
INSURANCE COMPANY ADDRI	FCC		NAME OF CL	AIMS ADJUSTER (if applicable)					
INSURANCE CONFANT ADDIN	L33				INAME OF CE	Alivis Absost Ett (ii applicable)			
		T	_		(16 11 1		T= - ==		
POLICY NUMBER		GROUP/PLAN NUMBE	R CLAIM NUM		1BER (if applicable)		CASE NUMBER		
SECONDARY INSURANCE									
SUBSCRIBER NAME			RELATIONSHIP TO PATI	ENT	SEX	DATE OF BIRTH	EMPLOYER		
INSURANCE COMPANY NAME					PHONE NUM	IDED.			
INSURANCE COMPANY NAME					PHONE NOW	DEN			
INSURANCE COMPANY ADDRI	PO		POLICY NUMBER		GROUP/PLAN NUMBER				
TERTIARY INSURANCE									
SUBSCRIBER NAME			RELATIONSHIP TO PATI	FNT	SEX	DATE OF BIRTH	EMPLOYER		
SOBSCIUDENTIA IIVIE			TREBATIONSTILL TO TAKE		JEA	DATE OF BIRTH	EWII EOTEK		
INCLIDANCE CONTRACTOR					DUI ONE NUM	1050			
INSURANCE COMPANY NAME					PHONE NUMBER				
INSURANCE COMPANY ADDRI	ESS			POLICY NUM	BER	GROUP/PLAN NUMBER			
AMORNERIS CONARENSATION (A	IO FALUE INCLIDA	NOS							
WORKER'S COMPENSATION/N	NO FAULT INSURA	NCE	DELATIONELUD TO DATE	ENT	CEV	DATE OF BIRTH	EMPLOYED		
SUBSCRIBER NAME			RELATIONSHIP TO PATI	EINI	SEX	DATE OF BIRTH	EMPLOYER		
INSURANCE COMPANY NAME			PHONE NUMBER						
INSURANCE COMPANY ADDRI	ESS		NAME OF CLAIMS ADJUSTER (if applicable)						
				application					
				T					
POLICY NUMBER GROUP/PLAN NUMBE			R	CLAIM NUME	BER (if applical	ble)	CASE NUMBER		
L		1					l .		