PATIENT REGISTRATION FORM
HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DEMOGRAPHICS

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 ❑ MALE ❑ INTERSEX	❑ FEMALE ❑ MALE	❑ SAME AS SEX LISTED WITH INSURANCE ❑ OTHER:_____	❑She/Her ❑ Ze/Hir ❑He/His/Him

PERMANENT STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS ❑MYCHART ❑ DISCHARGE INSTRUCTIONS ❑ DECLINE

TEMPORARY ADDRESS (IF APPLICABLE)	CITY	STATE	ZIP CODE

GENERAL INFORMATION

HISPANIC ETHNICITY?	RACE	ADDITIONAL RACE	ETHNICITY
❑ YES ❑ NO ❑UNKNOWN ❑ DECLINE			

FURTHER DESCRIPTION OF ETHNICITY # 1	FURTHER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH
		❑ VERY WELL ❑ WELL ❑ NOT WELL ❑ NOT AT ALL ❑ DECLINED ❑ UNAVAILABLE

WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?	IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?

WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? ❑ YES ❑NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ❑ YES ❑ NO

MARITAL STATUS	VISUALLY IMPAIRED? ❑ YES ❑NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? ❑ YES ❑ NO	NOTIFY PCP OF RESULTS? ❑ ALL ❑ ABNORMAL ❑ NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		

PATIENT'S EMPLOYER	PATIENT OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT	RETIREMENT DATE

EMPLOYER ADDRESS (no., stret, city, state, zip code)	EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME CONTACT #1	ADDRESS (no., street, apt#, city, state, zip code)

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

FULL NAME CONTACT #2	ADDRESS

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑ NO	SUPPORT PERSON? ❑ YES ❑ NO

PATIENT REGISTRATION DOWNTIME FORM
HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The person responsible for the bill)

GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE
EMPLOYER		OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? ❑ YES ❑ NO	INJURED BODY PART: ❑ RIGHT ❑ LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

TERTIARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		POLICY NUMBER		GROUP/PLAN NUMBER

WORKER'S COMPENSATION/NO FAULT INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME		PHONE NUMBER		
INSURANCE COMPANY ADDRESS		NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER	CLAIM NUMBER (if applicable)		CASE NUMBER

New Patient Questionnaire

Foot & Ankle

Name:		DOB:
Height:	Weight:	Age:

Occupation: _____

Full-time	Part-time

Chief Compliant

What is the reason for your visit? _____

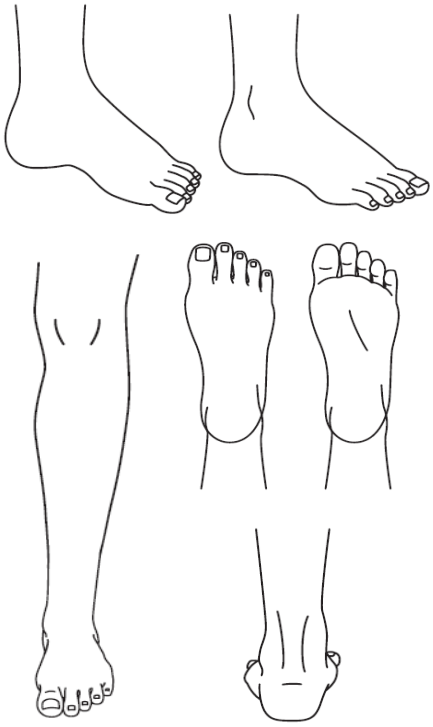
_____

_____

Current Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Please mark on the body diagram where you are experiencing pain:



When did this condition start? _____

Please explain how this condition started: _____

_____

Does anything make the pain better? _____

Does anything make the pain worse? _____

Do you wear Orthotics? Yes No

Please list any work activities, sports, or hobbies that are limited by your current problem: _____

_____

What is your level of play?

Professional	College
High School	Recreational

Have you tried any of the following?

Type	Date Range	Location/Describe	Effective?
Anti-Inflammatory Medications			Yes No
Cold Application			Yes No
Injections			Yes No
Physical Therapy			Yes No
Other:			Yes No

Medical and Family History

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	You	Family Member	Condition	You	Family Member
Anxiety	Yes		Open Wounds/Ulcers	Yes	
Arrhythmia (Irregular heartbeat)	Yes		Osteoarthritis	Yes	
Asthma	Yes		Osteoporosis	Yes	
Bleeding Problems	Yes		Peripheral Vascular Disease	Yes	
Blood Clots (DVT)	Yes		Pneumonia	Yes	
Cancer	Yes		Psychiatric Illness (Depression)	Yes	
Diabetes	Yes		Pulmonary Embolus	Yes	
Heart Attack	Yes		Reflex Sympathetic Dystrophy	Yes	
Heart Disease	Yes		Reflux	Yes	
High Blood Pressure	Yes		Rheumatoid Arthritis	Yes	
High Cholesterol	Yes		Seizures	Yes	
Infection	Yes		Stroke	Yes	
Kidney Disorders	Yes		Ulcers	Yes	
Lung Disease	Yes		Other:	Yes	

For Females Only: Do you think you may be pregnant at this time? Yes No

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)	Any Complications?
1.		
2.		
3.		
4.		
5.		

Social History

Are you a tobacco user? Yes No

Do you consume alcohol? Yes No

If yes, how many drinks per week? _____

Do you use any recreational drugs? Yes No

If yes, what kind(s): _____

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
Activity Change	Ear pain	Pain	Shortness of breath
Weight Change	Nosebleeds		Wheezing
None	None	None	None

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
Chest pain	Blood in stool	Excessive thirst	Difficult urination
Leg swelling	Heartburn	Excessive hunger	Frequent urination
Palpitations			
Poor circulation			
Pacemaker			
None	None	None	None

Skin	Neurological	Hematologic	Psychiatric
Healing Problems	Numbness	Bruises	Nervous/Anxious
Wound	Unsteady Walking	Excessive bleeding	Depression
None	None	None	None

Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions.

Please complete the information below:

Patient Name: _____

Preferred Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Alternate Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Laboratory Information

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to HSS laboratory.**

LabCorp	
Quest Labs	
HSS Lab	
Other External Location	

Please provide name of external location: _____