# 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<br>❑ MALE<br>❑ INTERSEX | ❑ FEMALE<br>❑ MALE | ❑ SAME AS SEX LISTED WITH INSURANCE<br>❑ 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<br>❑ RETIRED ❑ STUDENT | RETIREMENT DATE |
|---|---|---|---|
| | | | |

| EMPLOYER ADDRESS (no., street, 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 |
|---|---|---|---|---|---|
| | | | | | |

**PHARMACY INFORMATION**

**NAME:** _____

**ADDRESS:** _____

**PHONE NUMBER:** _____ **FAX NUMBER:** _____

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## 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<br>❑ RETIRED ❑ STUDENT | RETIREMENT DATE | | |
| EMPLOYER ADDRESS (no., street, city, state, zip code) | | | EMP PHONE | | |

## VISIT INFORMATION

| VISIT RELATED TO AN ACCIDENT OR INJURY?<br>❑ 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 |