

**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

HSS PHYSICIAN

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

OTHER

HAVE YOU EVER BEEN TO HSS FOR A DOCTOR OR HOSPITAL VISIT ?

Yes     No

IF SO, WHAT DOCTOR AND WHEN WERE YOU SEEN?

PATIENT'S FULL NAME (As it appears on Legal ID) [Last, First, Middle]

DATE OF BIRTH (MM/DD/YY)

AGE

COUNTRY

STREET ADDRESS (#, Street, Apt. #)

CITY

STATE

ZIP CODE

HOME PHONE

SEX

MARITAL STATUS

\*\*E - MAIL ADDRESS (Optional)

CELL PHONE (Optional)

EMPLOYMENT (If full time student, please provide school information)

PATIENT'S EMPLOYER (or School)

PATIENT OCCUPATION (or Student)

FULL-TIME     PART-TIME

RETIREMENT DATE (if applicable)

RETIRED     STUDENT

EMPLOYER (or School) ADDRESS (#, Street, City, State, Zip Code)

EMPLOYER (or School) PHONE

GUARANTOR (The person responsible for the bill)

SELF     PARENT/GUARDIAN     OTHER (If guarantor is not Self, please provide person's information below)

POLICY HOLDER (If other than Self) or GUARANTOR (If parent/guardian)

POLICY HOLDER - FULL NAME [Last, First, Middle]

RELATIONSHIP TO PATIENT

DATE OF BIRTH (MM/DD/YY)

ADDRESS (#, Street, Apt. #, City, State, Zip Code)

SEX

PHONE

FEMALE     MALE

EMPLOYER

OCCUPATION

FULL-TIME     PART-TIME

RETIREMENT DATE (if applicable)

RETIRED     STUDENT

EMPLOYER ADDRESS (#, Street, City, State, Zip Code)

EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME [Last, First, Middle]

RELATIONSHIP TO PATIENT

ADDRESS (#, Street, Apt. #, City, State, Zip Code)

SEX

PHONE

FEMALE     MALE

REFERRING PHYSICIAN INFORMATION (If applicable)

REFERRING PHYSICIAN & ADDRESS

ACCIDENT RELATED INFORMATION (Applies if your visit today is due to any accident or injury)

HOW DID YOUR INJURY OCCUR?

TYPE OF INJURY

DATE OF INJURY (MM/DD/YY)

PLACE OF INJURY (City, State)

PRIMARY INSURANCE (Please enter Worker's Comp or No Fault Information if applicable as Primary Insurance, otherwise enter Health/Medical Coverage)

INSURANCE COMPANY NAME

PHONE NUMBER

INSURANCE COMPANY ADDRESS

NAME OF CLAIMS ADJUSTER (if applicable)

POLICY NUMBER (SS# for Worker's Comp, No Fault)

GROUP/PLAN NUMBER

CLAIM NUMBER (for Worker's Comp and No Fault Claims)

WCB CASE NUMBER (if applicable)

SECONDARY INSURANCE (For Worker's Comp/No Fault patients, please enter Health/Medical Coverage as Secondary)

POLICY HOLDER - FULL NAME (If different than primary) (Last, First, Middle)

RELATIONSHIP TO PATIENT

DATE OF BIRTH (MM/DD/YY)

INSURANCE COMPANY NAME

PHONE NUMBER

INSURANCE COMPANY ADDRESS (#, Street, City, State, Zip Code)

POLICY NUMBER

GROUP/PLAN NUMBER

For Medicare Patients Only

ARE YOU CURRENTLY RESIDING IN A SKILLED NURSING FACILITY

OR INPATIENT FACILITY?

Yes     No

IF YES, PROVIDE NAME OF FACILITY

SKILLED NURSING FACILITY/REHAB FACILITY ADDRESS

PHONE NUMBER OF FACILITY

HIC # (Health Insurance Claim #)

**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 [MM/DD/YY] \_\_\_\_\_

**\*\* Hospital for Special Surgery may contact you with health-related information, including educational information about your condition.**