PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY

535 E 70th Street (Main) * **519 E 72nd Street** (Off Site)

Suite 202, New York, NY 10021

MR #

DATE OF VISIT

HOSPITAL PHYSICIAN

DR. P. ANDREOPOULOU

PATIENT'S LEGAL FULL NAME (Last, First, MI.) ★	SEX ★	DATE OF BIRTH ★	MARITAL STATUS ★
ADDRESS ★	SS # ★		HOME PHONE# ★
CITY, STATE, & ZIP CODE ★	RACE	ETHNICITY	CELL PHONE # ★
HAVE YOU BEEN TO THE HOSPITAL FOR SPECIAL SURGERY BEFORE? WHEN? ★	E-MAIL ADDRESS		

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER	OCCUPATION	❑ F/T ❑ P/T ❑ Retired ❑ Student	RETIREMENT DATE
EMPLOYER ADDRESS		EMPLOYERS' PHONE #	

GUARANTOR (PERSON RESPONSIBLE FOR INSURANCE CLAIM)

❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other

MEDICAL DETAILS

COMPLAINT / REASON FOR VISIT ★	ALLERGIES ★★

REF. PHYSICIAN / ADDRESS & CONTACT #

FILL IN THIS FIELD

PRIMARY INSURANCE

*PLEASE NOTIFY REGISTRAR IF PRIMARY INSURANCE IS NO FAULT, WORKMAN'S COMP, OR MEDICARE. (ADD'L FORMS)

INSURANCE COMPANY NAME & FULL ADDRESS			POLICY #/ID #	GROUP#/ACCOUNT #
NO FAULT OR WORKMAN'S COMP.			INSURANCE CLASS	CLAIM #
ACCIDENT DATE/TIME	ACCIDENT PLACE	NATURE OF ACCIDENT	CONTACT NAME & NO.	WCB CASE #

SECONDARY INSURANCE

INSURANCE COMPANY NAME & FULL ADDRESS			POLICY / ID #	GROUP#/ACCOUNT#
NO FAULT OR WORKMAN'S COMP.			INSURANCE CLASS	CLAIM #
ACCIDENT DATE/TIME	ACCIDENT PLACE	NATURE OF ACCIDENT	CONTACT NAME & NO.	WCB CASE #

PHARMACY DETAILS

PHARMACY NAME	PHARMACY PHONE #
PHARMACY ADDRESS	

FILL IN THIS FIELD

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, 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 X _____ **DATE** _____