

**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 <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> INTERSEX	SEX LISTED WITH HEALTH INSURANCE <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	WHAT IS YOUR GENDER IDENTITY? <input type="checkbox"/> SAME AS SEX LISTED WITH INSURANCE <input type="checkbox"/> OTHER: _____		PREFERRED PRONOUNS <input type="checkbox"/> She/Her <input type="checkbox"/> Ze/Hir <input type="checkbox"/> He/His/Him	
PERMANENT STREET ADDRESS			CITY	STATE	ZIP CODE
COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS	<input type="checkbox"/> MYCHART <input type="checkbox"/> DISCHARGE INSTRUCTIONS <input type="checkbox"/> DECLINE	
TEMPORARY ADDRESS (IF APPLICABLE)			CITY	STATE	ZIP CODE
GENERAL INFORMATION					
HISPANIC ETHNICITY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINE		RACE	ADDITIONAL RACE	ETHNICITY	
FURTHER DESCRIPTION OF ETHNICITY # 1		FURTHER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH <input type="checkbox"/> VERY WELL <input type="checkbox"/> WELL <input type="checkbox"/> NOT WELL <input type="checkbox"/> NOT AT ALL <input type="checkbox"/> DECLINED <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
MARITAL STATUS	VISUALLY IMPAIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS			
PATIENT CONTACTS					
PRIMARY CARE PROVIDER (PCP)		PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTIFY PCP OF RESULTS? <input type="checkbox"/> ALL <input type="checkbox"/> ABNORMAL <input type="checkbox"/> NONE	
REFERRING PROVIDER		REFERRING PROVIDER TELEPHONE			
PATIENT'S EMPLOYER		PATIENT OCCUPATION		RETIREMENT DATE	
		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME			
		<input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT			
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? <input type="checkbox"/> YES <input type="checkbox"/> NO	SUPPORT PERSON? <input type="checkbox"/> YES <input type="checkbox"/> NO
FULL NAME CONTACT #2		ADDRESS			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	SUPPORT PERSON? <input type="checkbox"/> YES <input type="checkbox"/> 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		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	RETIREMENT DATE
				<input type="checkbox"/> RETIRED <input type="checkbox"/> STUDENT	
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

**VISIT INFORMATION**

VISIT RELATED TO AN ACCIDENT OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	INJURED BODY PART: <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

**INSURANCE INFORMATION**

<b>PRIMARY INSURANCE</b>					
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	
<b>SECONDARY INSURANCE</b>					
SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER		
INSURANCE COMPANY ADDRESS			POLICY NUMBER	GROUP/PLAN NUMBER	
<b>TERTIARY INSURANCE</b>					
SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER		
INSURANCE COMPANY ADDRESS			POLICY NUMBER	GROUP/PLAN NUMBER	
<b>WORKER'S COMPENSATION/NO FAULT INSURANCE</b>					
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	