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

Dr. Fufa

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)	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 □ RETIRED □ STUDENT	RETIREMENT DATE (if applicable)
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 □ FEMALE □ MALE	PHONE
EMPLOYER	OCCUPATION	□ FULL-TIME □ PART-TIME □ RETIRED □ STUDENT	RETIREMENT DATE (if applicable)
EMPLOYER ADDRESS (#, Street, City, State, Zip Code)			EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME [Last, First, Middle]	RELATIONSHIP TO PATIENT	DATE OF BIRTH *(MM/DD/YY)*
ADDRESS (#, Street, Apt. #, City, State, Zip Code)	SEX □ FEMALE □ MALE	PHONE

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.