PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY
535 East 70th Street
NEW YORK, NY 10021

MEDICAL RECORD NUMBER

DATE OF VISIT

HOSPITAL PHYSICIAN SETH A. JERABEK, MD

PATIENT'S FULL NAME (last, first, MI.)	DATE OF BIRTH	BIRTH PLACE

ADDRESS (no., street, apt#, city, state, zip code)

COUNTY	HOME PHONE	SEX	RACE	MARITAL STATUS	SOC. SEC. NUMBER	RELIGION

TEMPORARY ADDRESS #1	CELL PHONE (if applicable)

EMPLOYMENT (If full-time student provide information on school)

PATIENT'S EMPLOYER	PATIENT OCCUPATION	❑ Full-Time ❑ Part-Time ❑ Retired ❑ Student	RETIREMENT DATE

EMPLOYER ADDRESS (no., stret, city, state, zip code)	EMP PHONE	E-MAIL ADDRESS

GUARANTOR (The person responsible for the bill)

❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other (If guarantor other than self, provide person's information below)

RELATIVES (Persons to be notified in case of emergency)

RELATIVE # 1 FULL NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH

ADDRESS (no., street, apt#, city, state, zip code)	SEX	HOME PHONE	SOC. SEC. NUMBER

EMPLOYER	OCCUPATION	❑ Full-Time ❑ Part-Time ❑ Retired ❑ Student	RETIREMENT DATE

EMPLOYER ADDRESS (no., street, city, state, zip code)	EMP PHONE

RELATIVE # 2 FULL NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH

ADDRESS (no., street, apt#, city, state, zip code)	SEX	HOME PHONE

MEDICAL DETAIL

COMPLAINT	ALLERGIES

REF. PHYSICIAN/ ADDRESS

PRIMARY INSURANCE: ■ MEDICAID ■ MEDICARE ■ BLUE CROSS ■ COMMERCIAL ■ WORKMEN'S COMP ■ NO-FAULT

INSURANCE COMPANY NAME	POLICY NUMBER

INSURANCE COMPANY ADDRESS	PHONE NUMBER

ACCIDENT DATE	ACCIDENT TIME	ACCIDENT PLACE	CLAIM NUMBER	WCB CASE NUMBER

NATURE OF ACCIDENT

SECONDARY INSURANCE: ■ MEDICAID ■ MEDICARE ■ BLUE CROSS ■ COMMERCIAL ■ WORKMEN'S COMP ■ NO-FAULT

INSURANCE COMPANY NAME	POLICY NUMBER

INSURANCE COMPANY ADDRESS	PHONE NUMBER

ACCIDENT DATE	ACCIDENT TIME	ACCIDENT PLACE	CLAIM NUMBER	WCB CASE NUMBER

NATURE OF ACCIDENT

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 efective 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 _____

V.S.