

**PATIENT REGISTRATION FORM**

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

MEDICAL RECORD NUMBER

DATE OF VISIT

HOSPITAL PHYSICIAN

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., street, 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 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 \_\_\_\_\_