

PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY

535 East 70th Street
NEW YORK, NY 10021

MR #
DATE OF VISIT
HOSPITAL PHYSICIAN DR. MARX

PATIENT'S LEGAL FULL NAME (Last, First, MI.) ★	SEX	Date of Birth ★	BIRTH PLACE	
ADDRESS ★	SS # ★	RELIGION		
CITY, STATE, & ZIP CODE ★	MARITAL STAT ★	RACE	HOME PHONE # ★	CELL PHONE # ★

HAVE YOU BEEN TO THE HOSPITAL FOR SPECIAL SURGERY BEFORE? WHEN?	E-MAIL ADDRESS
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EMPLOYMENT (if full-time student provide information on school / if patient is 65+ please fill out the back of the form)

PATIENT'S EMPLOYER ★	OCCUPATION ★	<input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> Retired <input type="checkbox"/> Student	RETIREMENT DATE ★
EMPLOYER ADDRESS (no., street, city, state, zip code) ★		EMPLOYERS' PHONE # ★	

GUARANTOR (the person responsible for the insurance claim)

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

GUARANTOR / EMERGENCY CONTACT

RELATIVE # 1 LEGAL FULL NAME Guarantor ONLY ★	RELATIONSHIP TO PATIENT ★	Date of Birth ★
ADDRESS (no., street, apt#, city, state, zip code) ★	MARITAL STAT ★	SEX ★
EMPLOYER ★	OCCUPATION ★	<input type="checkbox"/> F/T <input type="checkbox"/> P/T ★ <input type="checkbox"/> Retired <input type="checkbox"/> Student
EMPLOYER ADDRESS (no., street, city, state, zip code) ★		RETIREMENT DATE ★
EMPLOYER PHONE # ★		

RELATIVE # 2 FULL NAME (emergency contact)	RELATIONSHIP TO PATIENT	D.O.B.
ADDRESS (no., street, apt#, city, state, zip code)	SEX	HOME PHONE #
		CELL PHONE #

MEDICAL DETAIL

COMPLAINT / REASON FOR VISIT ★	ALLERGIES ★
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REF. PHYSICIAN / ADDRESS & CONTACT #
Please fill if applicable ★

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

INSURANCE COMPANY NAME & FULL ADDRESS (FOR CLAIMS)	POLICY # / ID #	GROUP# / ACCOUNT #
NO FAULT OR WORKMAN'S COMP. (NAME OF CO. AND FULL ADDRESS)	INSURANCE CLASS (PPO/EPO/POS/HMO)	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. (NAME OF CO. AND FULL ADDRESS)	INSURANCE CLASS (PPO/EPO/POS/HMO)	CLAIM #
ACCIDENT DATE / TIME	ACCIDENT PLACE	NATURE OF ACCIDENT
		CONTACT NAME & NO.
		WCB CASE #

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 _____

MEDICARE PATIENT'S ONLY, TURN 

**Confidential Medical History for Robert G. Marx, MD
HOSPITAL FOR SPECIAL SURGERY**

Name: _____ Today's Date: _____

Date of Birth: _____ Height: _____ Weight: _____ lbs.

List medical conditions/hospitalizations:

List prior surgery:

List problems with heart, lungs, stomach/colon, diabetes, cancer, neurological systems:

List medications:

List allergies to medications:

Have you ever had any problems with anesthesia? No Yes

Have you or anyone in your family had a blood clot or DVT? No Yes

Have you ever had a problem with easy bleeding or bruising? No Yes

Do you have a metal allergy? No Yes

Social History

Occupation: _____

Single Married Divorced Widowed

Live alone No Yes

Children? No Yes # _____

Smoke currently? No Yes: _____ Packs per day for _____ years.

Do not smoke now, but previously smoked _____ packs per day for _____ years.

Drink alcohol? No Yes #Drinks _____ per week or month (circle one)

History of substance abuse? No Yes What? _____

Who referred you to Dr. Marx? _____

Patient Signature: _____



Medicare Questionnaire

Patient name: _____ Date _____ MRI # _____

1. Are you entitled to Medicare based on?

- a. Age b. Disability c. End Stage Renal Disease

Only If you check **c. ESRD** fill out below

Have you received a kidney transplant? If Yes, date of transplant: _____

Have you received maintenance dialysis treatment? If Yes, date dialysis began: _____

Are you within the 30-month coordination period? Yes No

2. Are you currently employed (including self-employment and part-time employment)?

Yes How many people work for your employer? Less than 20 20 or more 100 or more

Name & Address of your employer _____

No If you are not employed, are you retired? If Yes, when did you retire? _____

No Never worked

3. Is your spouse currently working (including self-employment and part-time employment)?

Yes How many people work for their employer? Less than 20 20 or more 100 or more

Name & Address of Employer _____

No (Check if Deceased or No spouse.) If alive, when did your spouse retire? _____

No Never worked

4. Do you have Group Health Plan coverage based on your own, spouse's or family member's current employment?

Yes (Fill in information) Name & address of GHP: _____

No Policy / Group ID#: _____ Subscriber Name _____

Relationship _____

5. Is there any other benefit program (including government programs) that could pay for this service?

Yes (Check all that apply below)

No

Black Lung

VA/Tricare

Research Grant

Date benefits began: ____/____/____

If VA, has the Veterans' Affairs authorized and agreed to pay for care at this facility? Yes No

If yes, VA authorization # _____

(Black Lung is primary only for claims related to Black Lung. VA is primary only with VA letter of authorization)

6. Is this service related to an illness or injury that occurred while on your job or in an auto accident? (Or a result of another type of accident for which a person or business has been maybe held responsible?)

Yes (Fill out details) Date of accident or injury ____/____/____

No (No open case) Insurance company address _____

City: _____ State: _____ Zip: _____

Active Policy **or** Workers' Comp Case # _____

Type of accident: _____

(No Fault is primary only for those claims related to this accident. Worker's Compensation is primary only for claims resulting from work-related injuries/illness.)

Signature _____ Date _____