

**PATIENT REGISTRATION FORM**

**HOSPITAL FOR SPECIAL SURGERY**

535 East 70th Street  
NEW YORK, NY 10021

MR #
DATE OF VISIT
HOSPITAL PHYSICIAN <b>DR. MARX</b>

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
---	----------------

**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 ★	HOME PHONE # ★
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) ★		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 ★
-----------------------------------	----------------

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 