

**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

**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: \_\_\_\_\_

**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, & ZIPCODE ★	MARITAL STAT ★	RACE	HOME PHONE # ★	CELL PHONE # ★
TEMPORARY ADDRESS		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 FULL NAME (Guarantor ONLY / other than patient) ★		RELATIONSHIP TO PATIENT ★	Date of Birth ★
ADDRESS (no., street, apt#, city, state, zip code) ★		SEX ★	HOME PHONE # ★
EMPLOYER ★		OCCUPATION ★	<input type="checkbox"/> F/T <input type="checkbox"/> P/T <input checked="" type="checkbox"/> Student <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/spouse)		RELATIONSHIP TO PATIENT	D.O.B.
ADDRESS (no., street, apt#, city, state, zip code)		SEX	HOME PHONE
			SS#

**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. (ONLY)		INSURANCE CLASS (eg: PPO/EPO/POS)	CLAIM #
ACCIDENT DATE / TIME	ACCIDENT PLACE	NATURE OF ACCIDENT	CONTACT NAME & NO.
			WCB CASE #

**SECONDARY INSURANCE:**

INSURANCE COMPANY NAME & FULL ADDRESS		POLICY#	GROUP #
NO FAULT OR WORKMAN'S COMP. (ONLY)		INSURANCE CLASS (PPO/EPO/POS)	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 \_\_\_\_\_

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