PATIENT REGISTRATION FORM

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

MEDICAL RECORD NUMBER (FOR OFFICE USE ONLY)

DATE OF VISIT

HOSPITAL PHYSICIAN: Dr. Gulotta

LEGAL ID TYPE ☐ DRIVER'S LIC. ☐ PASSPORT ☐ BIRTH CERT. ☐ SSN ☐ GREEN CARD ☐ OTHER

PATIENT'S FULL NAME (Last, First, MI.)

DATE OF BIRTH | BIRTH PLACE

STREET ADDRESS | CITY | STATE | ZIP CODE

COUNTRY | HOME PHONE | SEX | RACE | MARITAL STATUS | SOC. SEC. NUMBER | CELL PHONE (if applicable)

TEMPORARY ADDRESS #1

E - MAIL ADDRESS

ARE YOU CURRENTLY RESIDING IN A SKILLED NURSING FACILITY OR INPATIENT REHAB FACILITY? ☐ YES ☐ NO

IF YES, PROVIDE NAME OF FACILITY

SKILLED NURSING FACILITY/REHAB FACILITY ADDRESS

PHONE NUMBER OF FACILITY

HAVE YOU EVER BEEN TO HSS FOR A DOCTOR OR HOSPITAL VISIT ? ☐ YES ☐ NO

IF SO, WHICH DOCTOR & WHEN WERE YOU SEEN?

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 (Insurance policyholder / the person responsible for the bill)

☐ SELF ☐ SPOUSE ☐ PARENT/GUARDIAN ☐ OTHER (If guarantor other than self, provide person's information below)

EMERGENCY CONTACT

PERSON # 1 FULL NAME (Complete this section for Spouse, Parent, Legal Guardian, etc.) | 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

PERSON # 2 FULL NAME | RELATIONSHIP TO PATIENT | DATE OF BIRTH

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

MEDICAL DETAIL

REASON FOR VISIT OR CHIEF COMPLAINT | ALLERGIES

IF YOUR SERVICE IS RELATED TO AN INJURY OR ACCIDENT - HOW DID YOUR INJURY OCCUR?

DATE OF INJURY | TIME OF INJURY | PLACE OF INJURY

REFERRING PHYSICIAN & ADDRESS

PRIMARY INSURANCE

INSURANCE COMPANY NAME | PHONE NUMBER

INSURANCE COMPANY ADDRESS | NAME OF CLAIMS ADJUSTER (if applicable)

POLICY NUMBER | GROUP/PLAN NUMBER | CLAIM NUMBER (if applicable) | WCB CASE NUMBER (if applicable)

SECONDARY INSURANCE

INSURANCE COMPANY NAME | PHONE NUMBER

INSURANCE COMPANY ADDRESS | POLICY NUMBER | GROUP/PLAN NUMBER

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 and a 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 _____

Name: _____ **Date:** _____

Date of birth: _____ **Age:** _____

Address: _____ **Telephone:** _____

_____

Email Address: _____

Occupation: _____

Referring doctor (if any): _____

Referring doctor's address: _____

_____

Why are you seeing Dr. Gulotta?

_____

_____

How long has this problem existed? _____

Is the problem a result of: _____ sports injury _____ work injury _____ accident

_____ fall _____ lifting _____ pulling

Other (please describe): _____

What have you done for this problem to date?

Medicine (ie, Tylenol, Motrin, etc.): _____

Physical therapy: _____

Injections (steroid shot): _____

Surgery: _____

What type of exercise/sports do you do? _____

Do you smoke? _____ # of packs? _____

Do you drink? _____ # of drinks? _____ day/week/mo

Do you have a history of substance abuse? _____

All information in this Worksheet is **Confidential**.

Medical History: Are you currently having or have you had problems with:

	YES	NO	Type
• Asthma/ lungs	_____	_____	_____
• High blood pressure	_____	_____	_____
• Heart disease	_____	_____	_____
• Digestion	_____	_____	_____
• Bleeding problems	_____	_____	_____
• High cholesterol	_____	_____	_____
• Immune deficiency	_____	_____	_____
• Difficulty urinating	_____	_____	_____
• Cancer	_____	_____	_____
• Diabetes	_____	_____	_____
• Sleep Apnea	_____	_____	_____
• Other (Please list)	_____		

Any family members with similar orthopaedic history or experiences?

_____

_____

Do you take any medications? Please list:

_____

_____

Previous surgery:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Do you have any allergies to medications?

Medicine: _____ Reaction: _____

_____ Reaction: _____

Other allergies (type): _____

All information in this Worksheet is **Confidential.**

April 14, 2003

Medical Record Number _____

ACKNOWLEDGMENT OF RECEIPT

By signing below, I acknowledge that I have been provided a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____
Signature of Patient or Patient's Personal Representative

_____
Print Name of Patient or Patient's Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

If you have any questions about this notice or would like further information, please contact the office manager.

For Office Use Only: If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.

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