Name:	
Chart:	
Date.	



PATIENT REGISTRATION FORM HOSPITAL FOR SPECIAL SURGERY

Patient Label

DATIENT D	EMOGRAE	PLICE							
PATIENT DEMOGRAPHICS			Tabasana www.			DATE OF BIRTH	COO CEO NUMBER		
NAME (AS LISTED ON IDENTIFICATION)			PREFERRED NAME			DATE OF BIRTH	SOC. SEC. NUMBER		
SEX ASSIGNED AT BIRTH SEX LISTED WITH HEALTH INSURANCE			WHAT IS YOUR GEN	IDER IDENTITY?		PREFERRED PRONOUNS			
□ FEMALE		□ FEMALE		☐ SAMES AS SEX	LISTED WITH INSU	JRANCE	☐ She/Her ☐ Ze/Hir ☐ He/His/Him		
□ MALE		☐ MALE							
□ INTERSEX			OTHER:						
PERMANENT STREET ADDRESS				dity	\$	STATE 2	P CODE		
COUNTRY	HOME PHON	NE	CELL PHONE		E-MAIL ADDRESS MYCHART		☐ DISCHARGE INSTRU	CTIONS DECLINE	
TEMPORARY ADDRESS (IF APPLICABLE)				CITY		STATE	ZIP CODE		
GENERAL I	INFORMAT	TION							
HISPANIC ETHN	NICITY?			RACE	ADDITIONAL RACE		ETHNICITY		
□ YES □	J NO □	UNKNOWN	□ DECLINE						
FURHTER DESC			FURHTER DESCRIPTION	OF ETHNICITY # 2	RATE YOUR ABIL	LITY TO SPEAK A	ND UNDERSTAND ENGLISH		
					□ VERY WELL □ WELL □ UNAVAILABLE		□ NOT WELL □ NOT AT ALL □ DECLINED		
WHAT IS YOUR	PREFERRED	SPOKEN LANGUA	AGE FOR HEALTH CARE IN	NSTRUCTIONS?	IN WHAT LANGU	AGE WOULD YOU	J PREFER READING HEALTH (CARE INSTRUCTIONS?	
WOLLD VOLLE	VE AN INTEDE	DETED EDEE OF	PELICION		WOLLD VOLLIE	E DELIGIOLIS SE	DVICES DI IDING INDATIENT S	TAV2	
WOULD YOU LIKE AN INTERPRETER FREE OF RELIGION CHARGE?				WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY?			IAT:		
□ YE	S □ NO					20			
MARITAL STATUS VISUALLY IMPAIRED?			PLEASE LIST ANY VISUAL OR HEARING NEEDS						
		□ YES	S □ NO						
PATIENT C	ONTACTO								
		OCD)	DOD TELEDHONE NUMBE	-D	NOTIFIX BOD OF	ADMICCIONS	NOTIFIX DOD OF BEGUI TO2		
PRIMARY CARE PROVIDER (PCP)		³ CP)	PCP TELEPHONE NUMBER		NOTIFIY PCP OF ADMISSION? YES NO		NOTIFIY PCP OF RESULTS? □ ALL □ ABNORMAL □ NONE		
REFERRING PROVIDER		REFERRING PROVIDER TELEPHONE							
PATIENT'S EMP	PLOYER		PATIENT OCCUPATION		I	□ FULL-TIME	□ PART-TIME	RETIREMENT DATE	
				□ RETIRED		☐ STUDENT			
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMPLOYER PHO				
	21.1200 (110.1, 01.1	00t, 0tty, 0tato, 2.p	3545)			20121111			
EMERGENO	CY CONTA	СТ							
FULL NAME CO	NTACT #1			ADDRESS (no., stree	t, apt#, city, state, z	ip code)			
HOME PHONE WORK NUMBER		CELL PHONE	RELATIONSHIP TO PATIENT		LEGAL GUARDIAN? ☐ YES ☐ NO	SUPPORT PERSON? ☐ YES ☐ NO			
FULL NAME CONTACT #2			ADDRESS (no., stree	., street, apt#, city, state, zip code)					
HOME PHONE WORK NUMBER			CELL PHONE	RELATIONSHIP TO PATIENT		LEGAL GUARDIAN?	SUPPORT PERSON?		

PHARMACY INFORMATION

NAME: ADDRESS:

PHONE NUMBER:

FAX NUMBER:

Name:			
Chart:			
Date:			

HOSPITAL
FOR
SPECIAL

PATIENT REGISTRATION DOWNTIME FORM HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The pe	erson responsibl	le for the bill)						
GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)					
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER		HOME PHONE		CELL PHONE	
EMPLOYER	1	OCCUPATION	<u>l</u>		□ FULL-TIME	□ PART-TIME	RETIREMENT DATE	
					□ RETIRED	☐ STUDENT		
EMPLOYER ADDRESS (no., str	reet, city, state, zip code)			EMP PHONE			
VISIT INFORMATION								
VISIT RELATED TO AN ACCIDI	ENT OR INJURY?	INJURED BODY PART	Γ: □ RIGHT □ LEFT	HOW DI	ID YOUR INJURY	OCCUR?		
□ YES	□ NO							
DATE OF INJURY		TIME OF INJURY		PLACE (OF INJURY			
INSURANCE INFORM	ATION							
					_			
PRIMARY INSURANC SUBSCRIBER NAME	<u> </u>		DELATIONSHIP TO DATIENT		SEX	DATE OF BIRTH	EMPLOYER	
SUBSCRIBER NAME			RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER	
INSURANCE COMPANY NAME PHONE NUM				MBER				
INSURANCE COMPANY ADDR	DECC		NAME C	ECLAIM	AD ILICTED (if a	ppliashla)		
INSURANCE COMPANY ADDRESS NAME OF CLAIM				ADDUCTER (ii applicable)				
POLICY NUMBER GROUP/PLAN NUMB		GROUP/PLAN NUMBE	BER CLAIM I		NUMBER (if applicable)		CASE NUMBER	
SECONDARY INSURA	ANCE							
SUBSCRIBER NAME			RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER	
INSURANCE COMPANY NAME			PHONE NUM	MBER				
INSURANCE COMPANY ADDRESS			POLICY NUMBER		3	GROUP/PLAN NU	IMBER	
					GROOT/I BANNOMBER			
TERTIARY INSURANCE	CE							
SUBSCRIBER NAME			RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER	
INSURANCE COMPANY NAME	<u> </u>		PHONE NUM	MBER				
INSURANCE COMPANY ADDRESS POLICY NUMBER			NUMBER	GROUP/PLAN NUMBER				
INSURANCE COMPANT ADDRESS FOLIOT NUMBER								
WORKERS' COMPEN	SATION/NO FAU	JLT INSURANCE			•			
SUBSCRIBER NAME			RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER	
INSURANCE COMPANY NAME			PHONE NUM	MBER	 	1	I	
INSURANCE COMPANY ADDRESS NAME OF CLAIM				ADJUSTER (if applicable)				
POLICY NUMBER GROUP/PLAN NUM		BER CLAIM!		M NUMBER (if applicable)		CASE NUMBER		
			-					
		•					•	