Name:
Chart:
Date:

PATIENT REGISTRATION FORM
HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)		PREFERRED NAME		DATE OF BIRTH	SOC. SEC. NUMBER
SEX ASSIGNED AT BIRTH ☐ FEMALE ☐ MALE ☐ INTERSEX	SEX LISTED WITH HEALTH INSURANCE ☐ FEMALE ☐ MALE	WHAT IS YOUR GENDER IDENTITY? ☐ SAMES AS SEX LISTED WITH INSURANCE ☐ OTHER: _____		PREFERRED PRONOUNS ☐ She/Her ☐ Ze/Hir ☐ He/His/Him	
PERMANENT STREET ADDRESS		CITY	STATE	ZIP CODE	
COUNTRY	HOME PHONE	CELL PHONE	E-MAIL ADDRESS ☐ MYCHART ☐ DISCHARGE INSTRUCTIONS ☐ DECLINE		
TEMPORARY ADDRESS (IF APPLICABLE)		CITY	STATE	ZIP CODE	

GENERAL INFORMATION

HISPANIC ETHNICITY? ☐ YES ☐ NO ☐ UNKNOWN ☐ DECLINE	RACE	ADDITIONAL RACE	ETHNICITY
FURHTER DESCRIPTION OF ETHNICITY # 1	FURHTER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH ☐ VERY WELL ☐ WELL ☐ NOT WELL ☐ NOT AT ALL ☐ DECLINED ☐ UNAVAILABLE	
WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?		IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?	
WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? ☐ YES ☐ NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ☐ YES ☐ NO	
MARITAL STATUS	VISUALLY IMPAIRED? ☐ YES ☐ NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS	

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFIY PCP OF ADMISSION? ☐ YES ☐ NO	NOTIFIY PCP OF RESULTS? ☐ ALL ☐ ABNORMAL ☐ NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		
PATIENT'S EMPLOYER	PATIENT OCCUPATION	☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT	RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)		EMPLOYER PHONE	

EMERGENCY CONTACT

FULL NAME CONTACT #1		ADDRESS (no., street, apt#, city, state, zip code)			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ☐ YES ☐ NO	SUPPORT PERSON? ☐ YES ☐ NO
FULL NAME CONTACT #2		ADDRESS (no., street, apt#, city, state, zip code)			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ☐ YES ☐ NO	SUPPORT PERSON? ☐ YES ☐ NO

PHARMACY INFORMATION
NAME:
ADDRESS:
PHONE NUMBER: **FAX NUMBER:**

Name:
Chart:
Date:

HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION DOWNTIME FORM
HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The person responsible 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		OCCUPATION	☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)			EMP PHONE		

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? ☐ YES ☐ NO	INJURED BODY PART: ☐ RIGHT ☐ LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY

INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME	PHONE NUMBER			
INSURANCE COMPANY ADDRESS	NAME OF CLAIMS ADJUSTER (if applicable)			

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

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME	PHONE NUMBER			
INSURANCE COMPANY ADDRESS	POLICY NUMBER	GROUP/PLAN NUMBER		

TERTIARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME	PHONE NUMBER			
INSURANCE COMPANY ADDRESS	POLICY NUMBER	GROUP/PLAN NUMBER		

WORKERS' COMPENSATION/NO FAULT INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME	PHONE NUMBER			
INSURANCE COMPANY ADDRESS	NAME OF CLAIMS ADJUSTER (if applicable)			

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