Name:	
Chart:	
Date:	



PATIENT REGISTRATION FORM HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DE	EMOGRAF	HICS							
NAME (AS LISTED ON IDENTIFICATION)			PREFERRED NAME			DATE OF BIRTH	SOC. SEC. NUMBER		
SEX ASSIGNED AT BIRTH FEMALE		WHAT IS YOUR GENDER IDENTITY? SAMES AS SEX LISTED WITH INSURANCE OTHER:			PREFERRED PRONOUNS ☐ She/Her ☐ Ze/Hir ☐ He/His/Him				
PERMANENTST	REETADDRE	SS		СІТҮ			STATE 2	P CODE	
COUNTRY	HOME PHON	NE .	CELL PHONE		E-MAIL ADDRESS MYCHART		☐ DISCHARGE INSTRUCTIONS ☐ DECLINE		
TEMPORARY AD	TEMPORARY ADDRESS (IF APPLICABLE)			CITY		STATE	ZIP CODE		
GENERAL II	NFORMAT	ION							
HISPANIC ETHN	ICITY?			RACE	ADDITIONAL RAC	CE	ETHNICITY		
□ YES □	NO 🗆	UNKNOWN	□ DECLINE						
FURHTER DESC	FURHTER DESCRIPTION OF ETHNICITY # 1 FURHTER DESCRIPTION			OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH VERY WELL NOT WELL NOT AT ALL DECLINET				
WHAT IS YOUR	PREFERRED	SPOKEN LANGUA	AGE FOR HEALTH CARE IN	NSTRUCTIONS?	IN WHAT LANGU	AGE WOULD YOU	U PREFER READING HEALTH (CARE INSTRUCTIONS?	
WOULD YOU LIKE AN INTERPRETER FREE OF RELIGION CHARGE? UPES NO				WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ☐ YES ☐ NO					
MARITAL STATU	JS	VISUALLY IMPAI		PLEASE LIST ANY V	ISUAL OR HEARING	G NEEDS			
PATIENT CO	ONTACTS								
PRIMARY CARE	PROVIDER (F	°CP)	PCP TELEPHONE NUMBER		NOTIFIY PCP OF ADMISSION? ☐ YES ☐ NO		NOTIFIY PCP OF RESULTS? □ ALL □ ABNORMAL □ NONE		
REFERRING PRO	OVIDER		REFERRING PROVIDER	TELEPHONE					
PATIENT'S EMPI	LOYER		PATIENT OCCUPATION		1	☐ FULL-TIME	□ PART-TIME	RETIREMENT DATE	
					□ RETIRED	□ STUDENT	1		
EMPLOYER ADD	DRESS (no., str	reet, city, state, zip o	code)			EMPLOYER PHO		<u> </u>	
EMERGENC	Y CONTA	СТ							
FULL NAME CON				ADDRESS (no., stree	et. apt#, citv. state, zi	in code)			
	111.01								
HOME PHONE	IE PHONE WORK NUMBER CELL PHONE		CELL PHONE	RELATIONSHIP TO PATIENT		LEGAL GUARDIAN?	SUPPORT PERSON?		
FULL NAME CON	NTACT #2			ADDRESS (no., stree	t, apt#, city, state, zi	ip code)			
HOME PHONE WORK NUMBER		CELL PHONE	RELATIONSHIP TO PATIENT		LEGAL GUARDIAN? ☐ YES ☐ NO	SUPPORT PERSON?			

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 per	son responsible	e for the bill)						
GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city	, state, zi	ip code)			
RELATIONSHIP TO PATIENT DATE OF BIRTH		SEX	SEX SOCIAL SECURITY NUMBER		HOME PHONE		CELL PHONE	
EMPLOYER		OCCUPATION			☐ FULL-TIME	□ PART-TIME	RETIREMENT DATE	
					-		•	
				☐ RETIRED ☐ STUDENT				
EMPLOYER ADDRESS (no., street	et, city, state, zip code)	1			EMP PHONE			
VISIT INFORMATION								
VISIT RELATED TO AN ACCIDENT OR INJURY? INJURED BODY PART: ☐ RIGHT ☐ LEFT HOW DID					D YOUR INJURY	OCCUR?		
☐ YES	□ NO							
DATE OF INJURY		TIME OF INJURY		PLACE (OF INJURY			
INSURANCE INFORMA	TION							
PRIMARY INSURANCE								
SUBSCRIBER NAME			RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER	
INSURANCE COMPANY NAME			PHONE NUM	/BER		<u> </u>	<u>I</u>	
INSURANCE COMPANY ADDRE	SS		NAME C	F CLAIM	ADJUSTER (if applicable)			
						,		
POLICY NUMBER		GROUP/PLAN NUMBE	ED CLAIMA		IUMBER (if applicable)		CASE NUMBER	
I OLIOT NOWIDLIK		CROOL/LEAN NOMBE	-IX	CLAIMIN	NOMBER (II applice	able)	CASE NOMBER	
OF COMPANY INCHES	VOE							
SECONDARY INSURAN SUBSCRIBER NAME	NCE		DEL ATIONICI IID TO DATIENT		OEV.	DATE OF DIDTH	EMPLOYED	
SUBSCRIBER NAME			RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER	
INSURANCE COMPANY NAME			PHONE NUM	/IBER				
INSURANCE COMPANY ADDRE	SS		POLICY NUMBER		1	JMBER		
TERTIARY INSURANCI	E							
SUBSCRIBER NAME			RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER	
INSURANCE COMPANY NAME			PHONE NUMBER			•		
INSURANCE COMPANY ADDRESS POLICY NUMB			POLICY	NUMBER GROUP/PLAN NUMBER			JMBER	
WORKERS' COMPENS	ATION/NO FALL	LTINSURANCE						
SUBSCRIBER NAME	ATION/NOTAG	LI MOOKANOL	RELATIONSHIP TO PATIENT		SEX	DATE OF BIRTH	EMPLOYER	
CODOCKIDEN IVINE			REEKTIONOTH TOTALLAT		OEX .	DATE OF BIRTH	EWI LOTEK	
INCLIDANCE COMPANY NAME			DHONE NUM	4DED				
INSURANCE COMPANY NAME			PHONE NUM	יוסבע				
				= 01 41::				
INSURANCE COMPANY ADDRESS			NAME C	AME OF CLAIM ADJUSTER (DJUSTER (if applicable)		
POLICY NUMBER GROUP/PL		GROUP/PLAN NUMBE	ER	CLAIM N	IM NUMBER (if applicable)		CASE NUMBER	