

PLEASE COMPLETE THE FOLLOWING INFORMATION:

NAME: _____ AGE: _____ GENDER: M F

DATE OF BIRTH: ____/____/____ EMAIL: _____

OCCUPATION: _____ IS THIS INJURY WORK RELATED? Yes No

CURRENT WORK STATUS: Full time Part time Homemaker Retired Disabled Not Employed

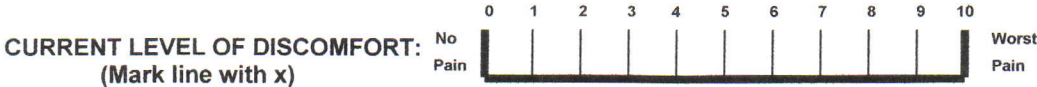
PLEASE LIST SPORTS OR ACTIVITIES: _____

THE CHIEF COMPLAINT: Foot Ankle Knee Shoulder Other (list): _____

SIDE: Right Left Both CIRCUMSTANCES OF ONSET WERE: Gradual Sudden

WHICH BEGAN ON: ____/____/____ (approximate date or state duration) _____ months / years

HOW DID THIS INJURY OCCUR? _____



THE DISCOMFORT IS: Getting Better Getting Worse Unchanged

THE QUALITY OF DISCOMFORT IS: Constant Intermittent Only With Activity Sharp Dull

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS (Please Check Any That Apply): Swelling
 Instability / Giving Way / Buckling Dislocation Clicking / Popping Locking / Catching Grinding
 Stiffness Rest Pain Night Pain Electric / Shooting Pains Numbness / Tingling

HAVE YOU EVER HAD OR BEEN TREATED FOR THIS PROBLEM IN THE PAST: Yes No (If No, go to next section)

TREATMENTS TRIED FOR THIS PROBLEM (Please Check Any That Apply):

- NONE Physical Therapy Applied Ice Applied Heat Activity Modifications
- Injection Orthotics Cast Rest ER VISIT
- X-rays MRI Cat Scan Bone Scan EMG / Nerve Study

Bracing (type) _____ Medications (name) _____

Surgery (List Procedure & Approx Date) _____

DO YOU HAVE ANY MEDICAL PROBLEMS OR ILLNESSES? Yes No

IF YES, PLEASE LIST (e.g. Diabetes): _____

HAVE YOU HAD ANY SURGERIES IN THE PAST? Yes No

IF YES, PLEASE LIST SURGERIES & APPROX DATES: _____

PLEASE LIST MEDICATIONS (Or Provide List): _____

DO YOU HAVE ANY ALLERGIES TO MEDICATION: Yes No (Please List): _____

DO YOU SMOKE? Yes No Quit _____ (Approx date) If Yes How Much? _____ packs /day

DO YOU DRINK ALCOHOL? Yes No Socially If Yes How Much? _____ drinks /day

DO YOU USE IV DRUGS? Yes No DO YOU EXERCISE REGULARLY? Yes No

NAME: _____ DATE OF BIRTH _____

PLEASE CHECK THE APPROPRIATE PAST MEDICAL HISTORY FOR YOURSELF AND YOUR FAMILY BELOW:

	YOURSELF		FAMILY		MOTHER	FATHER	SIBLING
ANXIETY	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
ARRHYTHMIA (Irregular Heartbeat)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
ASTHMA	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
BLEEDING PROBLEMS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
BLOOD CLOTS (Deep Vein Thrombosis/DVT)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
CANCER	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
HEART DISEASE	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
DIABETES	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
HEART ATTACK	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
HIGH BLOOD PRESSURE	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
HIGH CHOLESTEROL	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
INFECTION	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
KIDNEY DISORDERS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
LUNG DISEASE	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
OPEN WOUNDS / ULCERS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
OSTEOARTHRITIS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
OSTEOPOROSIS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
PERIPHERAL VASCULAR DISEASE	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
PNEUMONIA	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
PSYCHIATRIC ILLNESS (e.g. Depression)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
PULMONARY EMBOLUS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
REFLEX SYMPATHETIC DYSTROPHY	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
REFLUX	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
RHEUMATOID ARTHRITIS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
SEIZURES	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
STROKE	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____
ULCERS (Gastric, Duodenal)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	_____	_____

OTHER: (PLEASE SPECIFY): _____

PATIENT'S SIGNATURE: _____ Date ____/____/____

I attest the information is complete and accurate

(REQUIRED)

(OFFICE USE ONLY)

BP _____ RR _____ Pulse _____ Height _____ Weight _____

I attest that the above information was personally reviewed and updated.

PROVIDER SIGNATURE _____ **Date** ____/____/____

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

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

HOSPITAL PHYSICIAN

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, WHAT DOCTOR AND 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., street, city, state, zip code)

EMP PHONE

E - MAIL ADDRESS

GUARANTOR (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 _____