PATIENT REGISTRATION FORM

Hospital for Special Surgery 535 East 70th Street New York NY 10021	Medical Record Number (for staff use only)
	Hospital Physician Mark Drakos, MD

Patient full name			Date of Birth	
Street Address		City	State	Zip code
Primary phone number:		Secondary phone number:		

Email address:	Gender	Marital status
Emergency contact name	Relationship to patient	
Emergency contact phone number		
Patient employer's name		

Employer's address	City	State	Zip code
Employer's phone number			
Primary Insurance carrier name	Member ID		
Secondary Insurance carrier name	Member ID		
Workers Compensation carrier name, address and phone number	Carrier case number		Date of injury
Motor Vehicle Insurance company name, address and phone number	Claim number		Date of injury

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 Dr Drakos and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered. I further understand that it is my responsibility to know my own insurance coverage and its' limitations, terms and conditions.

If I have an insurance that Dr Drakos does not participate with, or I do not abide by the rules of my plan as described by my insurance carrier, I may be responsible for payment in full of services rendered. I am also aware that it is my responsibility to provide Dr Drakos' office with correct and current insurance information and a valid referral if my insurance plan requires one. If I fail to provide this information at any point during my treatment, I am aware I will be held responsible for all charges.

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 deductibleson all services and a 20% co-insurance on ancillary services. When Medicare is deemed the secondary carrier, I will follow payment terms under Hospital policies.

PATIENT OR GUARDIAN SIGNATURE	DATE

HOSPITAL FOR SPECIAL SURGERY

Mark Drakos, MD

INITIAL PATIENT VISIT - PLEASE COMPLETE THE FOLLOWING INFORMATION:

Name: ______________________ Age: ______ Gender: ☐ M ☐ F

Date of Birth: ____/____/____ Who Referred You to Us?: ______________________

Occupation: ______________________ Is This Injury Work Related? ☐ Yes ☐ No

Current Work Status: ☐ Full time ☐ Part time ☐ Homemaker ☐ Retired ☐ Disabled ☐ Not Employed ☐ N/A

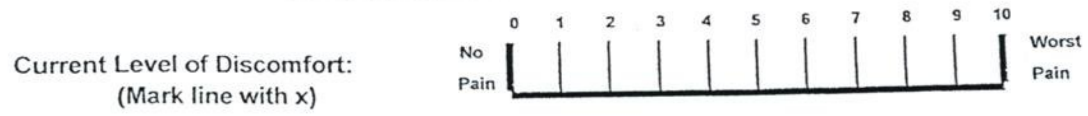
Please List Sports or Activities: ______________________

CHIEF COMPLAINT: ☐ Foot ☐ Ankle ☐ Knee ☐ Shoulder ☐ Other (list): ______________________

Side: ☐ Right ☐ Left ☐ Both How Did This Injury Occur? ______________________

When Did It Start?: ____/____/____ How Long Have You Been Having Symptoms?: ________ months / years

Current Level of Discomfort: (Mark line with x)



The Quality of the Discomfort: ☐ Constant ☐ Intermittent ☐ With Activity

The Discomfort Is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

Is There Any Recent Change in Shoewear or Activity? ☐ Yes ☐ No (If Yes, Describe): ______________________

Do You Have Any of the Following Symptoms (Please Check Any That Apply):

- ☐ Swelling
- ☐ Stiffness
- ☐ Dislocation
- ☐ Night Pain
- ☐ Locking / Catching
- ☐ Grinding
- ☐ Rest Pain
- ☐ Achiness / Dull Pains
- ☐ Clicking / Popping
- ☐ Numbness / Tingling
- ☐ Electric / Shooting / Sharp Pains
- ☐ Instability / Giving Way / Buckling

Did you injure or have pain in any other body areas? ☐ Yes ☐ No (If Yes, Describe): ______________________

Have You Ever Been Treated For This Problem in the Past?: ☐ Yes ☐ No (If No, go to next section)

What Treatments Have You Tried For This Problem (Please Check Any That Apply):

- ☐ NONE
- ☐ Injection
- ☐ X-rays
- ☐ Physical Therapy
- ☐ Orthotics
- ☐ MRI
- ☐ Ice / Heat
- ☐ Cast
- ☐ Cat Scan
- ☐ Rest
- ☐ Shoewear Changes
- ☐ Bone Scan
- ☐ Activity Modifications
- ☐ ER VISIT
- ☐ Bracing (type): ____________

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 And Approximate Dates: ______________________

Please List Medications (Or Provide List): ______________________

Do You Have Any Allegies To Medications?: ☐ 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 ☐	No ☐	Yes ☐	No ☐	____	____	____
ARRHYTHMIA (Irregular Heartbeat)	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
ASTHMA	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
BLEEDING PROBLEMS	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
BLOOD CLOTS (Deep Vein Thrombosis/DVT)	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
CANCER	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
DIABETES	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
HEART ATTACK	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
HEART DISEASE	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
HIGH BLOOD PRESSURE	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
HIGH CHOLESTEROL	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
INFECTION	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
KIDNEY DISORDERS	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
LUNG DISEASE	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
OPEN WOUNDS / ULCERS	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
OSTEOARTHRITIS	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
OSTEOPOROSIS	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
PERIPHERAL VASCULAR DISEASE	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
PNEUMONIA	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
PSYCHIATRIC ILLNESS (e.g. Depression)	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
PULMONARY EMBOLUS	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
REFLEX SYMPATHETIC DYSTROPHY	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
REFLUX	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
RHEUMATOID ARTHRITIS	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
SEIZURES	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
STROKE	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____
ULCERS (Gastric, Duodenal)	Yes ☐	No ☐	Yes ☐	No ☐	____	____	____

OTHER: (PLEASE SPECIFY): ____

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

I attest the information is complete and accurate

(THE SECTION BELOW IS FOR OFFICE USE ONLY) : I attest that the above information was personally reviewed and updated.

PROVIDER SIGNATURE ______________________________ Date _____/_____/_____

BBP: ☐ MRI
☐ CT
☐ XR
☐ Other ________

RTO: 1 / 2 / 3 / 4 / 5 / 6 / 7 weeks
1 / 2 / 3 / 6 / 12 months
☐ 6-8 weeks prn ☐ 3 months prn
☐ PRN

NNV: ☐ Ankle Xray WB
☐ Foot Xray WB
☐ Harris Heel View
☐ Pt will need cast next visit

☐ Ankle Xray NWB
☐ Foot Xray NWB
☐ Lateral Foot Xray WB
☐ Other: ____________