HOSPITAL FOR SPECIAL SURGERY EAST RIVER PROFESSIONAL BUILDING 523 East 72nd Street, 2nd FLOOR New York, New York, 10021	PATIENT REGISTRATION FORM	HSS #

DATE OF VISIT :	[ ] Dr. Boachie	[ ] Dr. Cooke	[ ] Dr. Fealy	[ ] Dr. Feinberg
	[ ] Dr. C. Lutz	[ ] Dr. G. Lutz	[ ] Dr. Rawlins	[ ] Dr. Simotas

PATIENT'S FULL NAME (Last, First, M.I.)	DATE OF BIRTH	SOC. SEC. NUMBER

ADDRESS (No., Street, Apt.#, City, State, Zip Code)

HOME PHONE	BUSINESS PHONE	SEX	MARITAL STATUS
TEMPORARY ADDRESS			BIRTHPLACE

EMPLOYMENT (If full-time student provide information of school)

PATIENT'S EMPLOYER	PATIENT OCCUPATION	[ ] Full-Time [ ] Part-Time [ ] Retired/ Date_____ [ ] Student
EMPLOYER ADDRESS (No., Street, City, State, Zip Code)		EMP. PHONE

GUARANTOR (The person responsible for bill) **If "self" check [ ] and skip to emergency contact**

FULL NAME (Last, First, M.I.)	RELATION TO PATIENT	DATE OF BIRTH	SOC. SEC. NUMBER
ADDRESS (No., Street, City, State, Zip Code)		SEX	HOME PHONE

EMERGENCY CONTACT

FULL NAME	RELATION TO PATIENT	CONTACT #

REFERRAL INFORMATION

REFERRED BY:	ADDRESS:
PHONE	**DRUG ALLERGIES**

COMPLAINT

ACCIDENT [ ] Yes [ ] No	ACCIDENT TYPE [ ] Vehicle [ ] Employment [ ] Other:	ACCIDENT DATE

INSURANCE INFORMATION (Please fill out ONLY if primary insurance holder is different than patient)

PRIMARY INSURANCE COMPANY NAME	INSURANCE POLICY #/MEDICARE/MEDICAID	GROUP OR CLAIM #
INSURANCE COMPANY ADDRESS		PHONE NUMBER

INSURED'S NAME	INSURED'S DATE OF BIRTH:	RELATION TO PATIENT:	SOC. SEC. #	WCB CASE #
SECONDARY INSURANCE COMPANY NAME	POLICY #		GROUP #	RELATION TO PATIENT:
COMPANY ADDRESSS	PHONE #	INSURED'S NAME		INSURED'S DATE OF BIRTH

Assignment and Release of information statement: I certify that the information provided 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 physician 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 and co-insurance payments on all services. When Medicare is deemed the secondary insurance, I will follow payment terms.

PATIENT OR GUARDIAN'S SIGNATURE:_____ **DATE:**_____