PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY
535 East 70th Street
NEW YORK, NY 10021

MEDICAL RECORD NUMBER
DATE OF VISIT
HOSPITAL PHYSICIAN **DR. FRAGOMEN**

PATIENT'S FULL NAME (Last, First, MI.)			SEX	D.O.B.	BIRTH PLACE
ADDRESS				SS #	RELIGION
CITY, STATE, & ZIPCODE	COUNTY	MARITAL STATUS	RACE	HOME PHONE #	CELL PHONE #
TEMPORARY ADDRESS				E-MAIL ADDRESS	

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)			EMPLOYERS' PHONE #

GUARANTOR (The person responsible for the bill)

❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other (If guarantor is other than self, provide person's information below)

GUARANTOR / RELATIVES

RELATIVE # 1 FULL NAME		RELATIONSHIP TO PATIENT		D.O.B. (For Guarantor Only)
ADDRESS (no., street, apt#, city, state, zip code)		SEX	HOME PHONE #	SS# (For Guarantor Only)
EMPLOYER (For Guarantor Only)	OCCUPATION (For Guarantor Only)	❑ Full-Time ❑ Part-Time ❑ Retired ❑ Student		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)				EMPLOYER PHONE #
RELATIVE # 2 FULL NAME (Person to be notified in case of emergency)		RELATIONSHIP TO PATIENT		D.O.B. (For Guarantor Only)
ADDRESS (no., street, apt#, city, state, zip code)		SEX	HOME PHONE	SS# (For Guarantor Only)

MEDICAL DETAIL

COMPLAINT	ALLERGIES
REF. PHYSICIAN / ADDRESS	

Please fill in

PRIMARY INSURANCE: ■ MEDICAID ■ MEDICARE ■ BLUE CROSS ■ COMMERCIAL ■ WORKMEN'S COMP ■ NO-FAULT

INSURANCE COMPANY NAME & FULL ADDRESS			POLICY#	GROUP #
ACCIDENT DATE	ACCIDENT TIME	ACCIDENT PLACE	INSURANCE COMPANY #	CONTACT NAME
NATURE OF ACCIDENT			CLAIM #	WCB CASE #

SECONDARY INSURANCE: ■ MEDICAID ■ MEDICARE ■ BLUE CROSS ■ COMMERCIAL ■ WORKMEN'S COMP ■ NO-FAULT

INSURANCE COMPANY NAME & FULL ADDRESS			POLICY#	GROUP #
ACCIDENT DATE	ACCIDENT TIME	ACCIDENT PLACE	INSURANCE COMPANY #	CONTACT NAME
NATURE OF ACCIDENT			CLAIM #	WCB CASE #

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, 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 _____

Austin T. Fragomen, MD
Orthopaedic Surgery

Please note that it is a requirement for the physician to document this information. Please answer all questions. Answer "none" if appropriate.

Date: _____

Name: _____ Email: _____

Home #: _____ Cell # _____Work #: _____

Birth Date: _____ Age: ____ Height: _____ Weight: _____ Blood Pressure: _____

Chief Complaint: _____

Primary MD (Name, Phone Number): _____

Referral Information:
Who referred you to Dr. Fragomen? _____

Are they a former patient of this office? _____

Information on the doctor(s) to whom you would like a report sent:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____

Did this doctor refer you here? _____

History of Present Illness:
Location: Where is the pain? _____

Quality: Circle one or more: sharp dull aching shooting traveling

Timing: When did it first start? _____

Is this a Work, Pedestrian or Motor Vehicle related injury? _____

Context: What causes the pain? _____

Frequency: How many times per week is it a problem? _____

Modifying Factors: What makes it worse? _____

What helps make it better? _____

Prior Treatment: _____

Past Medical History:
Major illness or injury: _____

Past Surgery: _____

Current Medications and what they are used to treat:

_____ _____

_____ _____

_____ _____

Allergies to medications: _____

Other Allergies ie. food: _____

Family History:

Medical Conditions that have been in your family: _____

Social History:

Marital Status: _____ Occupation: _____

Are you currently working? _____ If No, last date of work: _____

Alcohol use: How many drinks per week? _____

Smoking: How many packs per day? _____

Person you wish doctor to call in case of emergency or after surgery:

Name/Relation: _____ Telephone: _____

Person(s) able to be of assistance after surgery (explain): _____

_____

Review of Systems:

Please list any problems in the following systems: Indicate "none" if appropriate.

Cardiovascular, Heart: _____

Ear, Nose, Throat: _____

Endocrine, Hormonal, Diabetes: _____

Eyes: _____

Gastrointestinal, Digestive system, Liver: _____

Genitourinary: _____

Hematologic, Blood: _____

Immunologic, Immune compromise: _____

Integumentary, Skin: _____

Neurologic: _____

Peripheral circulation: _____

Psychiatric: _____

Renal, Kidney: _____

Respiratory, Lungs: _____

Do you have Sleep Apnea? _____ If Yes, do you use a CPAP/BIPAP? _____

Other:

Infection History-

Do you have a history of infection? _____ If Yes, what kind/When? _____

Name/Type of Antibiotics used, Duration? _____

Infectious Disease MD (Name, Phone Number): _____

Pain Management History-

Have you been followed by a Pain Management MD? _____ If Yes, current or past? _____

Name of Pain Medications and for how long? _____

_____

Pain Management MD (Name, Phone Number): _____

Are you involved in a lawsuit? _____

If so, please complete the following information:

Defendant: _____

Plaintiff: _____

Lawyer name: _____ Contact person: _____

Address: _____

Phone#: _____

For E-Prescribing purposes, please provide us your preferred pharmacy.

*Pharmacy Name: _____

Pharmacy Address: _____

*Pharmacy Zip: _____

Pharmacy Phone: _____

Patient Portal (www.healthtracker.com) is a secured website where you can view your medical record, update your personal information, request appointments, request prescriptions, and much more.

If you would like access to the patient portal please provide your email address below and you will receive an email with instructions.

Email: _____