HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION FORM

535 East 70th Street (Main) 519 East 72nd Street (Off site)
New York, NY 10021
HOSPITAL PHYSICIAN DR. METZL

MR#

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)	PREFERRED NAME	DATE OF BIRTH	SOC. SEC. NUMBER

SEX ASSIGNED AT BIRTH	SEX (legal) ☐ Male ☐ FEMALE	WHAT IS YOUR GENDER IDENTITY?	SEXUAL ORIENTATION
❑ FEMALE ❑ MALE ❑ INTERSEX	PREFERRED PRONOUNS ❑She/Her ❑ Ze/Hir ❑He/His/Him	☐ MALE ☐FEMALE ☐DECLINE ☐OTHER ☐TRANSGENDER FEMALE / MALE-TO-FEMALE ☐TRANSGENDER MALE / FEMALE-TO-MALE	❑ STRAIGHT ☐DON'T KNOW ❑ LESBIAN OR GAY ☐DECLINE ❑ SOMETHING ELSE

PERMANENT STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS

MARITAL STATUS	RACE	ETHNICITY	RELIGION

PATIENT INFORMATION

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? ❑ YES ❑ NO	NOTIFY PCP OF RESULTS? ❑ ALL ❑ ABNORMAL ❑ NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		

PATIENT'S EMPLOYER	PATIENT OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT	RETIREMENT DATE

EMPLOYER ADDRESS (no., street, city, state, zip code)	EMPLOYER PHONE

PHARMACY NAME/ADDRESS	PHONE	FAX

EMERGENCY CONTACT

FULL NAME CONTACT	ADDRESS (no., street, apt#, city, state, zip code)

HOME PHONE	CELL PHONE	WORK NUMBER	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ❑YES ❑NO	SUPPORT PERSON? ❑ YES ❑ NO

GUARANTOR / POLICY HOLDER

GUARANTOR FULL NAME	ADDRESS (no., street, apt#, city, state, zip code)

RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE

EMPLOYER	OCCUPATION	❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ STUDENT	RETIREMENT DATE

EMPLOYER ADDRESS (no., street, city, state, zip code)	EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? YES NO DATE OF INJURY	INJURED BODY PART: ❑ RIGHT ❑ LEFT	HOW DID YOUR INJURY OCCUR?

PRIMARY INSURANCE

INSURANCE COMPANY NAME/ADDRESS	POLICY NUMBER	GROUP/PLAN MUMBER

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER

INSURANCE COMPANY NAME/ADDRESS	PHONE 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/0r 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.

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 X_____ **DATE**_____

HOSPITAL FOR SPECIAL SURGERY

Medicare Questionnaire

Patient Name: _____ Date: _____ MR#_____

1. Are you entitled to Medicare based on?

A ☐ Age B.☐ Disability C. ☐ End Stage Renal Disease

Only if you check C **ESRD** fill out below

Have you received a kidney transplant? If Yes, date of transplant:_____

Have you received maintenance dialysis treatment? If Yes date dialysis began:_____

Are you within the 30-Month coordination period? ☐ Yes ☐ No

2. Are you currently employed (including self-employment and part-time employment)?

Yes ☐ **How many people work for your employer** ☐ Less than 20 ☐ 20 or more ☐ 100 or more

Name and Address of your employer _____

No ☐ If you are not employed, are you retired? If Yes, when did you retire?_____

No ☐ Never worked

3. Is your spouse currently working (including self-employment and part-time employment)?

Yes ☐ How many people work for your employer ☐ Less than 20 ☐ 20 or more v 100 or more

Name and Address of your employer _____

No ☐ (__Check if deceased of No Spouse.) If alive, when did your spouse retire?_____

No ☐ Never worked

4. **Do you have Group Health Plan coverage based on your own, spouse's or family member's current employment?**

Yes ☐ (Fill in information) Name & address of GHP:_____

No ☐ Policy/Group ID #_____Subscriber Name_____

Relationship_____

5. Is there any other benefit program (including government programs) that could par for this service?

Yes ☐ (Check all that apply below)

No ☐

☐ Black Lung ☐VA/Tricare ☐Research Grant

Date benefits began:____/____/____

If VA, has the Veterans' Affairs authorized and agreed to pay for care at this facility? ☐ Yes ☐ No

6. Is this service related to an illness or injury that occurred while on your job or in an auto accident? (Or a result of another type of accident for which a person or business has been maybe held responsible?)

Yes ☐ (fill out details) Date of accident or injury:____/____/____

No ☐ (No open case) Insurance company address_____

City: _____State:_____ Zip:_____

Active Policy or Workers' Comp Case #_____

Type of accident:_____

(No Fault is primary only for those claims related to this accident. Workers' Compensation is primary only for claims resulting from work-related injuries/illness.)

Signature: _____ Date:_____

Effective Date: April 14, 2003
Revision Date: October 7, 2013

HOSPITAL FOR SPECIAL SURGERY

Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy has long been highly valued at Hospital for Special Surgery. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of our Hospital and its medical staff and affiliated health care providers when providing health care services for our Hospital. Our Notice will be posted in the main entrance area of the Hospital at 535 East 70TH Street, New York, New York and in other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu, calling Health Information Management at (212) 606-1254, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by the Hospital, and how I may obtain access to and control this information. I also acknowledge and understand special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

If you have any questions about this Notice or would like further information, please contact the Privacy Officer at (212) 774-7500.

For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement.

_____

_____

_____

HOSPITAL FOR SPECIAL SURGERY

OUT PATIENT INTAKE FACE SHEET R/E/L Query

As part of a national initiative and rules enacted by the federal government, intended to insure that all patients receive the highest quality care, HSS will ask all of our patients to self report their race, ethnicity and preferred language for healthcare

If You Have Provided This Information To A Registrar Prior To this Visit Then You Do Not Have To complete This Survey For Subsequent Visits To HSS.

Thank you

1. Do you consider yourself to be Hispanic/Latino?
   ☐ Yes ☐ No

2. Which one or more categories best describes your race? Please check up to two only

   ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American

   ☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Some Other race

3. Please further describe your race or ethnic background? Please provide up to two responses.
   (For example: Mexican and Polish, Chinese and Caribbean American, Puerto Rican and Russian)

   _____ _____

4. How would you rate your ability to speak and understand English?
   ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

5. What is your preferred spoken language for discussing healthcare?

   (Provide one only.)_____

6. Would you like an Interpreter offered free of charge?
   ☐ Yes ☐ No ☐Not Applicable

7. In what language would you prefer reading medical or healthcare instructions?

   (Provide one only.)_____

PATIENT'S NAME:_____

New Patient Questionnaire

Jordan D. Metzl MD

HOSPITAL FOR SPECIAL SURGERY

Name:	DOB:	Height:	Weight:	Age:

Referring Physician: _____ Phone Number: _____

Employment Information:	**Occupation:**

Chief Complaint

What is the reason for your visit? _____

_____

_____

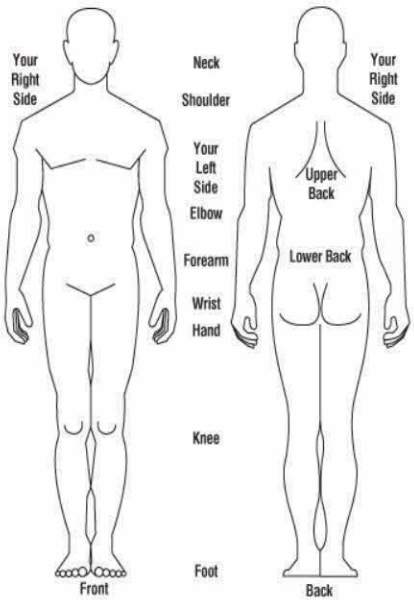
Please describe your symptoms:

Swelling	Stiffness	Locking	Instability
Giving Away	Numbness	Weakness	Tingling
Catching	Clicking	Other:	

Current Pain Level (no pain 0 – 10 highest):

1	2	3	4	5	6	7	8	9	10

Please mark on the body diagram where you are experiencing pain:



When did this condition start? _____

Please explain how this condition started (sudden, gradual, onset):

_____

Pain Frequency:	Constant	Intermittent	Rarely

Does anything make the pain better? _____

Does anything make the pain worse? _____

Do you participate in any sports? _____

Level of play (please select):

Professional	College	High School	Recreational

Have you had to modify your activities? Yes No

Are you still able to play sports/exercise? Yes No

Name: _____

Have you had or tried any of the following (please select and describe)?

Type	Date range	Location/Results	Effective?
Acupuncture Treatment			Yes No
Anti-Inflammatory Medications			Yes No
Chiropractic Treatment			Yes No
Injections			Yes No
Physical Therapy			Yes No
Massage Therapy/Deep Tissue			Yes No
MRI			
CT			
X-Ray			

Please list the physicians that have treated you previously for this problem:

Physician: _____Specialty:_____ Phone Number: _____

Physician: _____Specialty:_____ Phone Number: _____

Immunizations and Falls Screening:

Have you received the pneumonia vaccine? Yes No

If yes, date?_____ If not, why? _____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st?

Yes No If yes, date?_____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

Please list any allergies below (including medications, foods, and environment):

Drug Allergies	Reaction
1.	
2.	
3.	
4.	
5.	

Current Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Medical and Family History

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	You	Family Member	Condition	You	Family Member
Anxiety	Yes		Open Wounds/Ulcers	Yes	
Arrhythmia (Irregular heartbeat)	Yes			Yes	
Asthma	Yes			Yes	
Bleeding Problems	Yes			Yes	
Blood Clots (DVT)	Yes			Yes	
Cancer	Yes			Yes	
Diabetes	Yes			Yes	
Heart Attack	Yes			Yes	
Heart Disease	Yes			Yes	
High Blood Pressure	Yes			Yes	
High Cholesterol	Yes			Yes	
Infection	Yes			Yes	
Kidney Disorder	Yes			Yes	
Lung Disease	Yes			Yes	

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx..)
1.	
2.	
3.	
4.	
5.	

Social History

Are you a tobacco user? Yes No

Do you consume alcohol? Yes No

If yes, how many drinks per week? _____

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
Activity Change	Congestion	Dryness	Chest tightness
Appetite Change	Ear pain	Discharge	Choking
Chills	Nosebleeds	Itching	Cough
Fatigue	Sinus pressure	Pain	Shortness of breath
Fever	Sore throat	Redness	Wheezing
Weight Change			
None	None	None	None

Cardiovascular	Gastointestinal	Endocrine	Genitourinary
Chest pain	Abdominal pain	Cold intolerance	Difficult urination
Leg Swelling	Blood in Stool	Heat intolerance	Flank pain
Palpitations	Constipation	Excessive thirst	Frequent urination
Poor circulation	Heartburn	Excessive hunger	Painful urination
	Nausea		
None			

Muculoskeletal	Skin	Environmental Allergies	Neurological
Joint pain	Color change	Pollen	Dizziness
Joint Stiffness	Hair loss	DustMites	Headaches
Joint swelling	Rash	Pets/Animals	Light-headedness
	Skin tightening	Mold/Mildew	Memory loss
	Wound		Numbness
			Weakness
None	None	None	

Hematologic	Psychiatric	Other
Enlarged lymph nodes	Agitation	
Bruises	Hyperactive	
Clotting problem	Nervous/anxious	
Excessive bleeding	Depression	
None	None	

Name:_____

INSURANCE DISCLAIMER

Print Name_____ **DOB: ____/_____/_____**

With healthcare changing rapidly, we want to provide as much information in advance to help you navigate this process. Please contact your insurance ahead of time if you are unsure of the details of your policy. Even if we participate with your plan, the only way to know your responsibility with certainty is to contact your insurance. Some questions you may want to ask about are defined below.*

Please note: At present, we now participate with the following Affordable Care Act/Health Exchange insurances:

Empire Blue Cross Blue Shield- Pathway Enhanced

***If you are unsure if your insurance is a part of the Affordable Care Act, we advise you call your insurance or your employer to check on benefits and coverage.**

Dr. Metzl is **In Network** with the following insurance plans:

- **Aetna-** (except Aetna Medicare, Aetna Savings, Aetna exchange/ACA, and Aetna Signature), Referral Required for HMO and Student Health plans,
- **Empire Blue Cross Blue Shield** PPO and HMO, Anthem BCBS PPO, Horizon BCBS PPO (except: Blue Cross Prism EPO, Mediblue, and Blue Priority)
- GHI/Emblem Health plans (if obtained through an employer)
- **Medicare** (Government Issued)

*Disclaimer: Plans are changing all the time and you may have a new plan that is not listed here. Please always call to check your benefits to ensure participation status.

Radiology: Please be aware that **ALL** radiology, x-rays, MRI, ultrasounds, etc…are billed by the **main hospital**. If you do get any radiology services (x-rays, MRI, ultrasounds, etc) at the time of, or after your visit you will receive a separate bill from the **Hospital for Special Surgery**.

Signed Acknowledgement _____

***Coinsurance** is the term used by health insurance companies to refer to the amount that you are required to pay for a medical claim, apart from any co-payments or deductible. For example, if your health insurance plan has a 20% coinsurance requirement (and does not have any additional co-payment or deductible requirements), then a $100 medical bill would cost you $20, and the insurance company would pay the remaining $80. The amount of your co-insurance will vary depending on your particular plan.

****Deductible:** The amount you owe for health care services before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services. The deductible may not apply to all services and the amount varies according to your plan.

*****Referral**: An order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (**HMOs**), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services. These are done electronically or on a referral form and a copy should be presented at the time of your visit.