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

HOSPITAL PHYSICIAN

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

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., stret, 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 ____________

John D. MacGillivray, M.D.

Medical Profile

Name: ______________________________ **Today's Date:** ___________

Social Security #: ______________________ **Date of Birth:** ___________ **Age:** _______

Referring Physician: ___________________________ ***REQUIRED***

Referring Physician Address: _______________________________ ***REQUIRED***

____

Chief Complaint

Why are you seeing the doctor today? ____

Current problem is the result of a(n): Check all that apply

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other ___________________

This occurred during: Check all that apply

☐ Lifting ☐ Pulling ☐ Twisting ☐ Falling ☐ Bending ☐ Reaching ☐ Squatting

☐ Hit by Object ☐ Not known

List all medications you are currently taking:

Medication	Dose	How long?	Side Effects

ALLERGIES TO MEDICATION: ☐ **YES** ☐ **NO**

Name of Medication: ______________________ Reaction: _______________________________

______________________ _______________________________

Review of Systems

Are you currently having or have you had problems with your:

	Circle		**Describe all *Yes* responses**
Eyes	No	Yes	________________
Ears, Nose, Throat	No	Yes	________________
Lungs, Breathing	No	Yes	________________
Digestion	No	Yes	________________
Bowel movement	No	Yes	________________
Bladder problem	No	Yes	________________
Diabetes	No	Yes	Controlled: No Yes____
High blood pressure	No	Yes	________________
Bleeding problems	No	Yes	________________
Balance problems	No	Yes	________________
Numbness/tingling	No	Yes	________________
Blackout/fainting	No	Yes	________________
Psychological problems	No	Yes	________________
AIDS/HIV	No	Yes	________________
Cancer	No	Yes	________________
Arthritis	No	Yes	________________
Polio	No	Yes	________________
TB	No	Yes	________________
Epilepsy	No	Yes	________________

Current Specialists None _______

Cardiologist _____________________

____

Rheumatologist_____________________

____

Hematologist_____________________

____

Oncologist_____________________

____

Pain Management _____________________

____

Current Medical Conditions

Sleep Apnea ______ HepC ________

Pacemaker_______ Hemophilia ______

Insulin Diabetic ____ Coumadin ______

Liver Disease _____ Heparin ______

Sickle Cell ______ __________

Reviewed By: ____________________ MD Date: ___________ ***(NEXT PAGE)***

Name: ____ Today's Date: ______________

Social Security #: ______________________________ Date of Birth: ______________

Height ______ Weight ______ BMI ______ Blood Pressure ______ Pulse ______ Temp ______

Treatment to Date

☐ **Medication:** Name ________________________ ☐ **Physical Therapy:** ___________________________

☐ **Cortisone:** Effect__________________________ ☐ **Surgery:** Type ______________________________

Past Surgical History

List Type of Surgery	Year	Complications

Have you ever had general anesthesia? ☐ No ☐ Yes
Have any problems with anesthesia? ☐ No ☐ Yes Describe: _____________________________

Family History

Loose Joints:	
Arthritis:	
Diabetes:	
Gout:	

Social History

Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise? ____
History of substance abuse? ☐ No ☐ Yes What? __________________________________
Smoke currently? ☐ No ☐ Yes ____ Packs per day for ____ years
Quit smoking? ☐ This year ☐ >1 year ☐ >5 years ☐ >10 years
Previously smoked ____ Packs per day for ____ years
Drink alcohol? ☐ Daily ☐ 1-2x/week ☐ 1-2x/year

Medical Information Release: I authorize the staff of Dr. John D. MacGillivray, MD to discuss my medical history and medical condition with the following persons:
____________________________ Relationship______________________________
____________________________ Relationship______________________________
____________________________ Relationship______________________________

*Patient's Signature*______________________
Date:____________

John D. MacGillivray, M.D.
Hospital for Special Surgery
535 East 70th Street
New York NY 10021
(212) 606-1896

FINANCIAL POLICY

Thank you for choosing John D. MacGillivray, M.D. as your health care provider. We are committed to your treatment being successful. All patients must read and sign our Financial Policy before seeing Dr. MacGillivray.

Patients with Non Participating Plans

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA OR MATERCARD.

Patients Enrolled in Participating Plans

The billing office will submit to your carrier, however, you will be responsible for all deductibles and co-pays.

If you do not bring in your insurance identification card with you, payment in full is expected the day of service. Your insurance card must contain your policy, group or plan numbers, also the correct mailing address for claims to be submitted and the telephone number of the insurance company for verification.

If a referral is required and not presented at the time of service you understand that you will be responsible for any charges incurred at time of service.

In the event that your insurance changes to a plan in which Dr. MacGillivray does not participate, refer to the above paragraph concerning Non-Participating Plans. It is your responsibility to notify our office of any insurance changes. Failure to do so may result in being responsible for the services that incur under new insurance policy.

Minor Patients

The adult accompanying a minor to this office is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment has been pre-authorized to an approved health care carrier. Visa, MasterCard, cash or checks are acceptable at the time of service.

I have read Dr. MacGillivray's Financial Policy and agree to be bound to this Financial Policy.

X________________________________ Date________________
Signature of Patient or Responsible Party

X________________________________ Date________________
Signature of Co-Responsible Party

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Hospital for Special Surgery
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Cancellation Policy for Surgery

In an effort to serve our patients better we have instituted a cancellation policy for scheduled surgery dates. Surgery cancellations should be done more than 7 days prior to surgery.

Scheduling surgery is a time consuming and complicated process, and the office understands that it is very disruptive to your normal life. Likewise, when surgery is indicated, the office invests a considerable amount of time and effort beforehand, to ensure that the day of surgery goes as smoothly as possible.

From time to time, extenuating circumstances cause a surgery to be cancelled. However, in situations when the patient electively cancels a procedure within 7 days of the scheduled, **a non-refundable cancellation fee of $250 will be charged to the patient.**

If your surgery is cancelled for a medical reason this charge does not apply. Please keep this in mind when scheduling your surgical date.

I, ______________________________ have read and understand the surgical cancellation policy of Dr. John MacGillivray and I hereby accept and agree to adhere to the conditions of this policy.

____
Patient Signature or Parent/Guardian

____
Date

It is understood and agreed that my purpose of requesting examination and treatment is for medical purposes only and **NOT** in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate **IN ANY WAY** in the litigation, except to provide a true and accurate copy of any medical records and x-rays in the possession and control of this office pursuant to an authorization by the undersigned. *

* Upon payment of usual copying charges

Additionally, any forms that may be required by employers in connection to FLMA/Short Term Disability or for the purposes of transportation/travel accommodations are subject to an administrative charge of $10.00 per packet. This charge is the patient's responsibility due at the time the forms are submitted.

John D MacGillivray, MD, PC
Hospital for Special Surgery
535 East 70th Street
New York, NY 10021
Telephone: 212-606-1896

I. Insurance Status:

Patient Insurance Plan_______________________________

___Participating ___Non-Participating

*A complete list of insurances with which I participate is available at www.hss.edu/macgillivray

II. I am affiliated with **Hospital for Special Surgery** and the following hospitals:
   a. New York Presbyterian Hospital

III. During your procedure and/or hospital stay, we may request consultations by physicians who will also follow your case. These doctors will bill you separately.

IV. We recommend that you call each provider listed to confirm their participation status with your insurance company.

Below is a list of providers who may provide services as part of your prescribed treatment. Their contact information is also included

Name	Address	Telephone #
East River Medical Anesthesia*	535 East 70th Street, NYC	212-606-1206
HSS Radiology*	535 East 70th Street, NYC	212-774-2607
HSS Pathology*	535 East 70th Street, NYC	212-774-2607
East River Medical Imaging	519 East 72nd Street, NYC	212-288-1575
Park Avenue Orthotics	155 East 55th Street, NYC	212-297-0362

***Anesthesia, Radiology and Pathology participate in the same insurance plans as Hospital for Special Surgery. You can find a list of participating plans at www.hss.edu/insurance.**

V. Estimated charges for out of network service are available upon request.

VI. I have been informed of the insurance participation status of John D. MacGillivray, MD. I have reviewed the information provided to me and understand that the above providers may be involved in my care. I understand that it is my responsibility to contact each provider to determine participation status with my health plan.

Patient Name Signature Date