

**Stephen A. Paget, M.D.**  
*Hospital for Special Surgery*  
*535 East 70th Street, 7<sup>th</sup> Floor*  
*New York, N.Y. 10021*  
*Tel: 212-606-1471/ Fax: 212-606-1170*

**Patient Registration Form**

**Today's Date** \_\_\_\_\_

\*\*\* Must complete the following fields

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home#: \_\_\_\_\_ Work#: \_\_\_\_\_ ext: \_\_\_\_\_ Cell: \_\_\_\_\_

\*S.S. #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse/Partner: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

\*Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*Emergency Phone#: \_\_\_\_\_ Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Local Internist: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

\*Referred by Doctor: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**INSURANCE INFORMATION:**

*Please check your insurance policy for a waiting period before coverage or pre-existing clauses. If your coverage is contingent on a second opinion or pre-authorization or pre-admission, it is your responsibility to inform us.*

Primary Insurance		Secondary Insurance	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Policy Holder		Policy Holder	
Insured ID Number:	D.O.B	Insured ID Number:	D.O.B
Group Number/Name		Group Number/Name	
Phone		Phone	
Date of Accident:			

**Assignment Release of Information Statement:**

*I certify that the information given by me is correct and hereby authorize the release of information related to my medical care as requested by government agencies and/or insurance companies. I hereby assign benefits to Dr Paget and authorize payment directly to Dr Paget for services rendered. I understand that in the absences of accepted insurance coverage Legal Guardian responsible for full payment of services rendered. Medicare request that payment of authorized Medicare benefits be made on my behalf to Dr.Paget for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its Agents any information needed to determine these benefits payable for related services.*

**We currently do not accept most insurance. You will receive a bill for the service that are being rendered to you.**

**PATIENT/AUTHORIZED SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_