HOSPITAL FOR SPECIAL SURGERY

Dr. Edwin Su

New Patient Form

First Name | M.I. | Last Name | Suffix

Social Security Number: ___ - __ - ____

Date of Birth: __ / __ / ____

Address: ______________________

City: ______________________

State: __ Zip: _____

Home Number: ___ - ___ - ____

Work Number: ___ - ___ - ____

E-mail: ______________________

Occupation: ______________________

Employer: ______________________

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: ______________________

Phone: ___ - ___ - ____

Emergency Contact (other than spouse): ______________________

Phone: ___ - ___ - ____

Referring Physician: ______________________

Work Number: ___ - ___ - ____

Address: ______________________

City: __________ State: __ Zip: _____

Ethnicity (Check all that apply):

☐ White/Caucasian (not Latino/Hispanic) ☐ Asian/Oriental/Pacific Islander

☐ Black/African American ☐ American Indian/Native Alaskan

☐ Latino/Hispanic/Mexican American ☐ Other (Specify):______________

Primary Insurance Information:

Primary Insurance: ______________________

Insured Name: ______________________

Type of Insurance:

☐ PPO ☐ Fee-for-Service/Private
☐ HMO ☐ Veteran's Affairs/Other Military
☐ Medicaid ☐ FEHB Program (Federal)
☐ Medicare ☐ No Insurance/Self-Pay
☐ Medicare Supplement ☐ No Insurance/Charity

Secondary Insurance Information:

Secondary Insurance: ______________________

Insured Name: ______________________

Type of Insurance:

☐ PPO ☐ Fee-for-Service/Private
☐ HMO ☐ Veteran's Affairs/Other Military
☐ Medicaid ☐ FEHB Program (Federal)
☐ Medicare ☐ No Insurance/Self-Pay
☐ Medicare Supplement ☐ No Insurance/Charity

Assignment: I certify that the information given by me is correct. I hereby authorize the release of information related to my medical care as requested by government agencies and/or insurance carriers. I understand that the doctor I am seeing does not participate in any HMO Plans, and that I am responsible for any deductible, co-payment, and balance after my claim(s) has/have been processed. I hereby assign benefits to my physician and understand that in the absence of insurance coverage I am responsible for full payment for services rendered.

Signature: ______________________ Date: __ / __ / ____

HOSPITAL FOR SPECIAL SURGERY

Edwin Su, M.D.

Medical Profile

Current Medications (Please include ***prescription drugs*** and drugs you buy ***over the counter***)

Medications:	Reason for taking:	Dose:	Frequency:
1.			
2.			
3.			
4.			
5.			
6.			

Past Medical History

Please list allergies:	Reaction:
1.	
2.	
3.	

Review of Systems:

Are you currently having or have had any problems with:

- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Palpitations
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Productive Sputum
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Ulcers
- ☐ Thyroid
- ☐ IBS
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Hepatitis/Liver Disease
- ☐ HIV
- ☐ Urinary Problems
- ☐ Lupus
- ☐ Cancer
- ☐ Seizures
- ☐ Gout
- ☐ Anxiety
- ☐ Depression
- ☐ Weight Loss
- ☐ Anemia
- ☐ Varicose Veins
- ☐ Tuberculosis
- ☐ Eyes
- ☐ Ears, Nose, Throat
- ☐ Bleeding Tendency
- ☐ Other 1. ________ 2. ________

Previous Illnesses:	Previous Operations:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

Do you smoke? ☐ Yes ☐ No

If yes, number of packs per day? ☐☐ Number of years? ☐☐

Do you drink? ☐ Yes ☐ No

If yes, number of drinks per week? ☐☐ Number of years? ☐☐