



# David J. Mayman MD

Joint Replacement and Sports Medicine  
Hospital for Special Surgery  
535 East 70<sup>th</sup> Street, New York, NY 10021  
(212) 774-2024

## New Patient Registration and Demographics

### Personal Information:

Patient Name: _____	Date of Birth: _____
Address: _____	Gender: M F
_____	Telephone #: Home _____
_____	Office _____
Social Security Number: _____	Cell _____

### Emergency Contact Information:

Name: _____	Address: _____
Relationship: _____	_____
Telephone #: _____	_____

### Employment or School Information:

Employer or School: _____	Occupation: _____
Employer Address: _____	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
_____	<input type="checkbox"/> Retired <input type="checkbox"/> Student
_____	Employer's Tel. #: _____

### Medical Insurance:

Insurance Company Name: _____
Insured's Name: _____
Insurance Company Address: _____
_____
_____
Policy Number: _____
Insurance company tel. #: _____

### Referring Physician:

Name: _____
Tel. #: _____
Address: _____
_____
_____
Would you like a copy of your notes sent to your referring physician? Yes No

### Guarantor / Policy Holder if Not Patient:

Full Name: _____	Date of Birth: _____
Home Address: _____	Social Security Number: _____
_____	Employer: _____
_____	Occupation: _____
Employer Address: _____	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
_____	<input type="checkbox"/> Retired <input type="checkbox"/> Student
_____	Employer Telephone 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 Dr. Mayman's computer database which exists on the hospital network. I hereby authorize sharing of this and future information with hospital affiliated physicians, government agencies, and / or insurance carriers. I hereby authorize payments to be made directly to Dr. Mayman.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_