# STONY BROOK SURGICAL ASSOCIATES
## PATIENT DEMOGRAPHIC FORM (new patients only)

**Patient Information**

| Name (Last, First, MI) | | | | Date |
|---|---|---|---|---|
| Street Address | City | State | Zip | |

| Home Phone ( ) ☐Preferred | Work Phone ( ) ☐Preferred | Cell Phone ( ) ☐Preferred |
|---|---|---|

| SSN | Date of Birth | Gender ☐Female ☐Male | Marital Status ☐ N/A (Child) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated |
|---|---|---|---|

| Religion (optional) | Ethnicity (optional) | e-mail address |
|---|---|---|

**Financially Responsible Party**

Is patient responsible party/guarantor? ☐ Yes ☐ No

| Name (Last, First, MI) | Relationship to patient |
|---|---|

| Street Address | City | State | Zip |
|---|---|---|---|

| Home Phone ( ) ☐Preferred | Work Phone ( ) ☐Preferred | Cell Phone ( ) ☐Preferred |
|---|---|---|

| Occupation | Employer | Date of Birth |
|---|---|---|

**Emergency Contact**

| Name | Relationship to Patient |
|---|---|

| Home Phone ( ) ☐Preferred | Work Phone ( ) ☐Preferred | Cell Phone ( ) ☐Preferred |
|---|---|---|

**Referral Info**

| Referring Physician's Name | Physician Phone/Fax (if known) ( ) |
|---|---|
| Physician Address | How did you hear about us? ☐ Physician ☐ Friend ☐Website ☐Newspaper ☐Radio/TV ☐ Other ____________________________ |

**PCP Info**

| Primary Care Physician's Name ☐ Same as Referring Physician above | Physician Number ( ) |
|---|---|

**Insurance Info**

| Primary Insurance Company | Policy # | Group # |
|---|---|---|

| Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐Other _______________ | Name of Subscriber (if other than patient) |
|---|---|

| Subscriber's Social Security # | Gender ☐ Male ☐ Female | Date of Birth | Employer of Subscriber | Work Phone ( ) |
|---|---|---|---|---|

| Secondary Insurance Company | Policy # | Group # |
|---|---|---|

| Patient's Relationship to Insured ☐ Self ☐ Spouse ☐Child ☐ Other _______________ | Name of Subscriber (if other than patient) |
|---|---|

| Subscriber's Social Security # | Gender ☐ Male ☐ Female | Date of Birth | Employer of Subscriber | Work Phone ( ) |
|---|---|---|---|---|

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____________________________________________________________ Date: ______/______/______

Guarantor Signature (if other than patient): ___________________________________ Date: ______/______/______