

STONY BROOK SURGICAL ASSOCIATES

PATIENT DEMOGRAPHIC FORM (new patients only)

Patient Information	Name (Last, First, MI)						Date	
	Street Address				City		State	Zip
	Home Phone () <input type="checkbox"/> Preferred		Work Phone () <input type="checkbox"/> Preferred		Cell Phone () <input type="checkbox"/> Preferred			
	SSN	Date of Birth	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		Marital Status <input type="checkbox"/> N/A (Child) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
	Religion (optional)	Ethnicity (optional)		e-mail address				
Financially Responsible Party	Is patient responsible party/guarantor? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	Name (Last, First, MI)				Relationship to patient			
	Street Address				City		State	Zip
	Home Phone () <input type="checkbox"/> Preferred		Work Phone () <input type="checkbox"/> Preferred		Cell Phone () <input type="checkbox"/> Preferred			
	Occupation		Employer		Date of Birth			
Emergency Contact	Name				Relationship to Patient			
	Home Phone () <input type="checkbox"/> Preferred		Work Phone () <input type="checkbox"/> Preferred		Cell Phone () <input type="checkbox"/> Preferred			
Referral Info	Referring Physician's Name				Physician Phone/Fax (if known) ()			
	Physician Address		How did you hear about us? <input type="checkbox"/> Physician <input type="checkbox"/> Friend <input type="checkbox"/> Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio/TV <input type="checkbox"/> Other _____					
PCP Info	Primary Care Physician's Name <input type="checkbox"/> Same as Referring Physician above				Physician Number ()			
	Primary Insurance Company		Policy #		Group #			
Insurance Info	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				Name of Subscriber (if other than patient)			
	Subscriber's Social Security #		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber	Work Phone ()		
	Secondary Insurance Company		Policy #		Group #			
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				Name of Subscriber (if other than patient)			
	Subscriber's Social Security #		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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: ____/____/____							