

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

<b>Patient Information</b>	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		Ethnicity (optional)		
	Name of Parent or Legal Guardian (Last, First, MI)			Relationship		Email		
	Street Address <input type="checkbox"/> Same as Patient				City		State	Zip
	Home Phone ( ) <input type="checkbox"/> Preferred		Work Phone ( ) <input type="checkbox"/> Preferred		Cell Phone ( ) <input type="checkbox"/> Preferred			
<b>Financially Responsible</b>	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			
<b>Emergency Contact</b>	Name				Relationship to Patient			
	Home Phone ( ) <input type="checkbox"/> Preferred		Work Phone ( ) <input type="checkbox"/> Preferred		Cell Phone ( ) <input type="checkbox"/> Preferred			
<b>Referral Info</b>	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 _____					
<b>PCP Info</b>	Primary Care Physician's Name <input type="checkbox"/> Same as Referring Physician above				Physician Number ( )			
<b>Insurance Info</b>	Primary 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 ( )			
	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: ____/____/____								