EL0020

Stony Brook Southampton Hospital

240 Meeting House Lane Southampton, NY 11968

PATIENT LABEL

DOWNTIME REGISTRATION QUESTIONNAIRE

For Registration use:

Restriction: **Opt in** ____ **Opt out** ____

Have you ever been a patient at Stony Brook Southampton Hospital before? ☐ Yes ☐ No

Date: _____

Time: _____

Doctor: _____

Patient Information

Patient Information:

Name (Last): _____ (First) _____ (Middle)_____

Alternate names:

List all other names by which you have been known by_____

Nickname:_____

Patients maiden name:_____ Mothers maiden name:_____

Social Security #: _____ - _____ - _____

Date Of Birth: _____

(Month) (Day) (Year)

Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Home phone:_____ Mobile phone:_____

Email Address:_____

Alternate Address: _____

City:_____ State:_____ Zip Code: _____

Alternate Phone: _____

Race:

☐ American Indian ☐ Asian Indian ☐ Black/African American ☐ Chinese ☐ Declined ☐ Filipino

☐ Hispanic ☐ Japanese ☐ Korean ☐ Native ☐ Other ☐ Vietnamese ☐ White

Ethnicity:

☐ Central American ☐ Cuban ☐ Declined ☐ Dominican ☐ Latin American ☐ Mexican American

☐ Non-Hispanic ☐ Puerto Rican ☐ South ☐ Spaniard ☐ Unknown

Marital Status: Please check one:

☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Registered Domestic Partner

Preferred Spoken Language: Other:_____ (write in the name of the other language)

☐ English ☐ American Sign ☐ Spanish ☐ Other

Preferred Written Language: _____

Are you a Veteran? Circle one:

Active Duty, Not a Veteran, Part-time active, Veteran

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Religion: Please check one:

☐ Adventist ☐ Athiest ☐ Baptist ☐ Buddhist ☐ Roman Catholic ☐ Christian ☐ Congregational
☐ Declined to answer ☐ Episcopalian ☐ Greek Orthodox ☐ Hindu ☐ Jewish ☐ Jehovah Witness
☐ Lutheran ☐ Methodist ☐ Mormon ☐ Muslim ☐ Non-Denominational ☐ Other ☐ Pentacostal
☐ Presbyterian ☐ Protestant ☐ Unitarian ☐ Unknown ☐ Zoroastrian ☐ Quaker

Primary Care Physician: _____
City: _____ State: _____
Contact #: _____

Employment Status: Please circle one:

Full time, Part-time, Reserved for National Assignment, Retired, Retired Military
Self- employed, Student full time, Student part time,
Unemployed Cobra eligible, Unemployed not Cobra eligible

Employer Name:_____
Employer Address:_____
City:_____ State:_____ Zip Code: _____
Business Phone Number: _____ Extension:_____
Occupation:_____

Emergency Contacts

What is the patients relationship to the emergency contact: _____
Name (Last): _____ (First) _____(Middle)_____
Address:_____ City:_____
Primary Phone #: _____ Mobile Phone #: _____

Legal next of Kin

Relationship to patient: _____ Is address same as patient? _____ Yes _____ No
Name (Last): _____ (First) _____ (Middle)_____
Mailing Address: _____
City:_____ State:_____ Zip Code: _____
Primary Phone #: _____ Mobile Phone #: _____

For Patient Access Staff Only

Chief Complaint:
Accident/Therapy/Treatment: _____
Date/Time: _____ Event: _____
Place/Qual: _____ State: _____

Registrar Sign-Off

_____ **Insurance Cards Scanned** _____ **Insurance Verified** _____ **ID Cards Scanned**

_____ **Obtained Consents** _____ **Obtained MSPQ**

_____ **Registrar Initials** _____ **Date** _____ **Time**