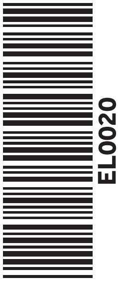


Stony Brook
Southampton Hospital
240 Meeting House Lane Southampton, NY 11968

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

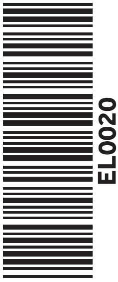
Marital Status: Please check one:
☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Registered Domestic Partner

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

Form #0924E (03/20)
(Rev. 03/20)



Stony Brook Southampton Hospital

240 Meeting House Lane Southampton, NY 11968

PATIENT LABEL

DOWNTIME REGISTRATION QUESTIONNAIRE

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**