



PATIENT REGISTRATION

Patient's Name: First Middle Last Suffix SSN: - -

Email: Preferred Method of Contact: Circle One - Email / Home / Cell / Work

PHONE: Home Work: Cell:

Address:

City: State: Zip:

Date of Birth: Age:

Marital Status: Single Married Divorced Widowed Legally Separated Unknown Deceased Subscriber

Select RACE: Caucasian (White) Black/African American Asian Native American Asian Pacific American Pacific Islander Subcontinent Asian American Native Hawaiian American Indian or Alaskan Native

Sexual Orientation: Straight Gay Lesbian Bisexual Other Unknown Declined

Sex/Gender Identity: Male Female Declined Transgender Male/Female to Male Transgender Female/Male to Female Gender-queer; neither Exclusively Male nor Female Other

Select Ethnicity: Latino/Hispanic Not Hispanic or Latino Other Refused Not Reported

Preferred Language:

Employed: Full Time Part Time Retired Student

Employer: Emergency Contact: Relationship: Phone: Preferred Pharmacy: Phone:

BILLING: If you are NOT the Subscriber, please provide: Subscriber Name: Relationship to Subscriber: Subscriber's Date of Birth:

DISCLOSURE Our Notice of Privacy Practices provides information about how we may use or disclose medical information about you. A copy of this policy is made available in our waiting room, you may request a copy from the Front Desk, or download a copy from our website: www.npspecialists.com

Please Initial: I have been provided an opportunity to review the Notice of Privacy Policy. In addition to the policies set forth in the Notice of Privacy Practices regarding the release of my medical information, I authorize Neurology and Sleep Associates of Suffolk to discuss my healthcare with the following individuals:

Name/Relationship Name/Relationship

