STONY BROOK ORTHOPAEDIC ASSOCIATES

Date:___/___/___

New Patient Questionnaire-Podiatry ☐ Dr. Jason Behar ☐ Dr. Lisa Riccio

Name: ______________________________ Date of Birth: __/___/___ ☐ Male ☐ Female
Street: __________________________ City: __________________ State: ____ Zip: _______
Home #: ________________ Cell #: _________________ Other #: ___________________
Email: ____ Social Security#: ___/___/___
Emergency Contact Name: _________________________________ Phone #: ______________

Primary Insurance: ___________________________________ Are you the insured? ☐ Yes ☐ No
Subscriber name: ____________________ Relationship to Insured? ☐ Spouse ☐ Child ☐ Self ☐ Other
ID#: ______________________ Group #: _______________ Date of birth: ____/___/____
Is this insurance from your employer? ☐ Yes ☐ No Employer: ____________________________
Is a referral required? ☐ Yes ☐ No
Secondary Insurance: ________________________________ Are you the insured? ☐ Yes ☐ No
Subscriber Name: ____________________ Relationship to insured? ☐ Spouse ☐ Child ☐ Self ☐ Other
ID#: ______________________ Group#: ________________ Date of birth: ____/___/____
Is this insurance from your employer? ☐ Yes ☐ No Employer: ______________________________
Is a referral required? ☐ Yes ☐ No

Primary Care Physician: ______________________________ Phone #: ___________________
Street: _____________________________ City: ________________ State: _____ Zip: _______
Please let us know who referred you to us:
Referring Physician: _________________________________ Phone #: ___________________
Street: _____________________________ City: ________________ State: _____ Zip: _______

Do you have Diabetes? ☐ Yes ☐ No
If yes, please fill in the following information.
When were you diagnosed with Diabetes: ___/___/___
Treating Physician: _________________________________ Phone #: ____________________
Street: _____________________________ City: ________________ State: _____ Zip: _______
Date last seen for diabetes: ___/___/___
Type of Diabetes: ☐ Type I ☐ Type II
Any Complications: ☐ No complications
Yes: ☐ Neuropathy ☐ Retinopathy ☐ Kidney ☐ Skin ☐ Other
If Other, Please explain: ____

Please circle one: ☐ Working ☐ Retired
Employer: ____ Phone #: __________________
Street: ____________________________ City: __________________ State: _____ Zip: _______