

Steinmetz Medical Associates, P.C.  
**PATIENT REGISTRATION**

**GENERAL INFORMATION**

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home: \_\_\_\_\_ Cell: \_\_\_\_\_  
Work: \_\_\_\_\_ Ext: \_\_\_\_\_

Rendering Physician: Steinmetz Shiffman Lee  
D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Sex: Male Female  
Marital Status: Married Single Divorced Widow  
Social Security No.: \_\_\_\_-\_\_\_\_-\_\_\_\_  
Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Relation: \_\_\_\_\_  
Home: \_\_\_\_\_  
Work: \_\_\_\_\_ Ext: \_\_\_\_\_

**RESPONSIBLE PARTY**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_ Sex: Male Female

**INSURANCE INFORMATION**

Insurance Co.: \_\_\_\_\_  
Policy/ID #: \_\_\_\_\_  
Group #: \_\_\_\_\_

PolicyHolder: \_\_\_\_\_  
*(If different than Patient)*  
PolicyHolder's  
DOB: \_\_\_\_/\_\_\_\_/19\_\_\_\_  
PolicyHolder's  
SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Relation to Patient: Self Spouse Parent/Guardian Other

**MISCELLANEOUS INFORMATION**

E-Mail: \_\_\_\_\_

**Pharmacy Information**

Local Pharmacy: _____	Mail Order Pharmacy: _____
Address (or street name) _____	Address _____
City: _____ State: _____	City: _____ State: _____
Phone #: _____	Phone #: _____
Fax #: _____	Fax #: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? Family Website Newspaper Physician  
Friend Letter INOVA Health Source Other: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_