Steinmetz Medical Associates, P.C.

PATIENT REGISTRATION

GENERAL INFORMATION

Last Name: ______________________________

First Name: ______________ M.I.: ________

Address: ______________________________

Address: ______________________________

City ______________________________

State ________ Zip Code: ________

Home Tel.: ______________________________

Cell #: ______________________________

Work Tel.: ______________ Ext: ________

Rendering Physician: Steinmetz Shiffman Lee

How did you hear about our practice?________________

Family Website Newspaper Physician Friend Letter

INOVA Heath Resource Other: ____________________

Birth Date: _____/_____/______

Sex: Female Male

Marital Status: Married Single Divorced Widow

Social Security No.: ________-________-__________

Employer: ______________________________

Employ Status: Full-time Part-time Retired Not Employed

Student: **Yes** **No**

RESPONSIBLE PARTY

Name: ______________________________

Phone: ______________________________

Relationship: ______________________________

Sex: **Female** **Male**

EMERGENCY CONTACT

Name: ______________________________

Phone: ______________________________

Relationship: ______________________

Work Phone: ______________________

INSURANCE INFORMATION

Insurance Co.: ______________________________

Policy/ID #: ______________________________

Group #: ______________________________

Relation to Patient: Self Spouse Parent/Guardian Other

PolicyHolder: ______________________________
(If different than Patient)

PolicyHolder's DOB: _______/_______/________

PolicyHolder's SSN: __________-________-____________

ADDITIONAL INFORMATION

E-Mail: ____

Pharmacy Information

Local Pharmacy: ______________________

Address(or street name) ______________________

City: ______________________ State: ______

Phone #: ______________________________

Fax #: ______________________________

Mail Order Pharmacy: ______________________

Address ______________________________

City: ______________________ State: ____

Phone #: ______________________________

Fax #: ______________________________

Date: _____/______/20____