STEINWAY HOPE MEDICAL

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Patient Registration Form

Appointment phone #:_____ Email:_____

DEMOGRAPHIC INFORMATION

Last Name:_____ First Name:_____ M.I.:_____
Date of Birth: _____ Age: _____ Sex: M / F Marital Staus:_____
Street Address: _____ City: _____
State:_____ Zipcode:_____ Home #: _____ Mobile#:_____
Referring Doctor: _____
Preferred Pharmacy: _____ Pharmacy Location:_____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____
Home phone#: _____ Mobile#: _____

Is this patient covered by Health Insurance? Yes / No
If No: Payment Method: _____CASH, _____ CHECK

INSURANCE INFORMATION
(Please give your Insurance card and ID to the receptionist)

Insurance Name.: _____
Member ID Number : _____

I verify that the above information is factual and true to the best of my knowledge. I authorize the Family Nurse Practitioner Gifty J. Appiah to do the necessary procedures and test so that I will receive the proper care I need. I understand that payment, proof of insurance, and/or copay is due at the time of service. I authorize this office to apply benefits on my behalf for the covered services rendered.
I hereby accept responsibility for payment for services provided to me that is not covered by my insurance.
I certify that the insurance information I have provided is factual and correct.

_____ _____
Signature of the Patient Date