St. Peter Medical Center
3058 Metropolitan Parkway Ste. 204
Sterling Heights, MI 48310

Patient Registration: Date_____

How did you hear about this clinic_____

Name_____ Patients Social Security Number_____

Street Address _____City _____State___ Zip_____

Date of Birth _____ Marital Status S M W SEP D Sex M F

Telephone #: Home_____ Alternate #_____

Spouse's Name _____ Spouse's Employer_____

Emergency Contact _____Tel#_____ Relationship_____

Referred By:_____

Patient Employer Information

Employer Name_____Tel#_____

Employer Street Address_____ Pt Occupation_____

Insurance Information

Primary Insurance Company Name _____Effective Date_____

ID#_____ Group#_____ Tel#_____

Policyholder information: Self_____ Relationship to patient (circle one) Spouse/ Parent

Subscriber Name_____ Tel#_____ **Date of Birth**_____

Street Address_____City/State_____Zip_____

Secondary Insurance Company Name_____ Cardholder_____

ID#_____Group#_____Tel #_____

Policyholder information: Self_____ Relationship to patient (circle one) Spouse/ Parent

Subscriber Name_____ Tel#_____ **Date of Birth**_____

Street Address_____City/State_____Zip_____

I hereby authorize Dr. Nouri to treat my symptoms and apply for benefits on my behalf for any services rendered by him, or his order.
I request that payments of authorized benefits from Medicare/Insurance Company be made directly to Dr. Nouri.
I authorize Dr. Nouri to release any medical information about me to HCFA/my insurance and its agents,
any information needed to determine these benefits or the benefits payable to related services.
I authorize the use of this authorization for any of my insurance submissions.
I understand that I am responsible for any amount not covered by my insurance company(s).
I certify the information that I have reported with regards to my insurance coverage is correct.
I permit a copy of this authorization to be used in place of its original.
This authorization may be retrieved by either me or my insurance company at any time in writing.

Patient Signature_____ Date_____