

ADULT PATIENT INFORMATION

New Established

Chart ID _____

*** Anyone 18 years or older will be considered an adult and placed on their own account ***

PATIENT	Legal Name (Please provide full legal name below)		
	Last		
	First		
	Middle	Alternate Name (Preferred, Nickname, Maiden Name)	
	Social Security Number	Marital Status	M S D W <input type="checkbox"/> Male <input type="checkbox"/> Female
	Date of Birth	Student Status <input type="checkbox"/> Not a student <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
	Address		
	City	State	<input type="checkbox"/> Home (Landline)
	Zip Code	<input type="checkbox"/> Cell	
	Employer	<input type="checkbox"/> Work	
Emergency Contact (person NOT living with patient to contact):			
Name	Relationship to patient	Phone	

NOTE Mercy Clinics, Inc. routinely does family billing (all family member charges appear on one family bill). This bill may be addressed to the person listed below as the subscriber of the primary insurance.

SPOUSE	Legal Name (Please provide full legal name below)		
	Last		
	First		
	Middle	Alternate Name (Preferred, Nickname, Maiden Name)	
	Address	Social Security Number	
	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	
	City	State	Student Status <input type="checkbox"/> Not a student <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Zip Code	<input type="checkbox"/> Home (Landline)	
	Employer	<input type="checkbox"/> Cell	
	Employer	<input type="checkbox"/> Work	

Please provide all pertinent information regarding your insurance coverage and present your current insurance card to the receptionist.

I have no insurance, please address the bill to:
 Patient Spouse

My Medicare insurance is not prime because:
 Patient or spouse employed Disability Other

INSURANCE	Primary Insurance		Person Carrying Ins.
	Effective Date	Ins ID#	Date of Birth
	Group #	Relation to Patient	SS#
	Secondary Insurance		Person Carrying Ins.
	Effective Date	Ins ID#	Date of Birth
	Group #	Relation to Patient	SS#

By signing this, I verify that this information is correct and that I am ultimately financially responsible for any charges incurred.

X _____
 Signature Date

Clinic use only Updated/Reviewed Date _____ Date _____ Date _____ Date _____

OTHER	How did you hear about Mercy Clinics?	<input type="checkbox"/> Friend	<input type="checkbox"/> Physician	<input type="checkbox"/> Radio
	<input type="checkbox"/> Print Advertisement	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Internet Ad/Search	<input type="checkbox"/> Television Commercial
				<input type="checkbox"/> Other _____