

*** 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)	
	Social Security Number	<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 <input type="checkbox"/> Home (Landline)		
	City	State	Zip Code
	Mother's Name	Date of Birth	Does patient live with mom? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Father's Name	Date of Birth	Does patient live with dad? <input type="checkbox"/> Yes <input type="checkbox"/> No
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.

SIBLINGS	Please list below all siblings under the age of 18 who live at the same address as the patient listed above.			
	Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	SS#
	Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	SS#
	Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	SS#

PARENT OR GUARDIAN WHO THE PATIENT LIVES WITH	Legal Name (Please provide full legal name below)		
	Last		
	First	Alternate Name (Preferred, Nickname, Maiden Name)	
	Middle	Social Security Number	
	Address	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
	City	Student Status <input type="checkbox"/> Not a student <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
	State	*Check preferred contact number*	
	Zip Code	Spouse's Name	<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: Parent/Guardian

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			