mercy COMMUNITY HEALTHCARE

MERCY COMMUNITY HEALTHCARE
REGISTRATION FORM - ADULT

(Please Print)

Do you have a child that has been previously seen at Mercy? ❑ Yes ❑ No If **yes**, please list name and date of birth below.

Child's Name: Child's Birth date:

Today's date:	PCP:	Pharmacy:	Phone:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	Preferred Name:

Birth date: / /	Age:	Gender: ❑ M ❑ F	Social Security No:	Primary Language:

Please check all boxes that apply to the patient:
Race: ❑ African American/Black ❑ American Indian/Alaskan Native ❑ Asian ❑ Caucasian/White
❑ Native Hawaiian/Pacific Islander ❑ Other Race

Please Check One:
❑ Hispanic or Latino
❑ Not Hispanic or Latino

Marital status (circle one): Single / Married / Live-In Partner / Divorce / Separated / Widowed

Street address:	City:	State:	Zip Code:

Home phone No.: ( )	Cell phone No.: ( )	Primary phone No.: ( )	Email:

Contact Preferences: ❑ Home Phone ❑ Cell Phone Is it okay to leave a message at the box you have selected? ❑ Yes ❑ No

Current Living Arrangement: ❑ Public Housing ❑ Live in Own Home ❑ Spouse/Significant Other's Home ❑ Parent/Relative's Home
❑ Foster Home ❑ Group Home ❑ Friend's Home ❑ Homeless/Shelter** ❑ Refused
**Date of homeless status:_____ ❑ Homeless Shelter ❑ Transitional ❑ Doubling Up ❑ Street ❑ Other

EMPLOYMENT INFORMATION

Occupation:	Employer:	Employer address:	Employer phone No.: ( )

SPOUSE INFORMATION

Is your spouse a patient here at Mercy? ❑ Yes ❑ No

Last Name:	First:	Middle:	Preferred Name:

Birth date: / /	Age:	Gender: ❑ M ❑ F	Social Security No:	Primary Language:

Please check all boxes that apply :
Race: ❑ African American/Black ❑ American Indian/Alaskan Native ❑ Asian ❑ Caucasian/White
❑ Native Hawaiian/Pacific Islander ❑ Other Race

Please Check One:
❑ Hispanic or Latino
❑ Not Hispanic or Latino

Street Address (if different than patient):	City:	State:	Zip Code:

Home phone No.: ( )	Cell phone No.: ( )	Primary phone No.: ( )	Email:

If applicable, please provide a copy of any paperwork regarding medical power of attorney, conservatorship, advance directive, etc.

PATIENT PORTAL INVITATION

Mercy Community Healthcare will send you an invitation at the email you provided to sign up for a patient portal account. You will be able to communicate with your healthcare team via the patient portal and submit requests for medication refills and future appointments. Please see a patient service representative, if you have any questions.

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INSURANCE INFORMATION

(Please give your insurance card to the patient service representative.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone No.: ( )

Are you covered by insurance? ❑ Yes ❑ No (If **No**, you must complete a Self-Pay Program Application)

Please indicate primary insurance	Subscriber's name:	Subscriber's S.S. No.:

Birth date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group No.:	Policy No.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF AN EMERGENCY

Name of local friend or relative (not at same address):	Relationship to patient:	Home phone No.: ( )	Work phone No.: ( )

How did you hear about Mercy Community Healthcare? ❑ Internet ❑ Patient ❑ Radio ❑ Yellow Pages ❑ Outside Physician ❑ Advertisement ❑ Referral Service

Are you a United States Veteran? ❑ Yes ❑ No

Are you an agricultural worker? ❑ Yes ❑ No If **Yes**, please check the appropriate status below.

❑ Employed Year Round ❑ Seasonal Worker ❑ Migrant Worker ❑ Retired Farmworker

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mercy Community Healthcare or insurance company to release any information required to process my claims.

Patient/Legal Patient Representative Signature *Date*

Legal Patient Representative (Please Print)