MERCY COMMUNITY HEALTHCARE
REGISTRATION FORM - PEDIATRICS

(Please Print)

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

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

SIBLING INFORMATION

Name	Birth Date	Age	Gender

PARENT/LEGAL GUARDIAN INFORMATION

Is this parent/legal guardian 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:

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

Relationship to patient: ❑ Mother ❑ Father ❑ Legal Guardian ❑ Foster Parent ❑ DCS ❑ Case Worker ❑ Other:____

Marital status (circle one) Single / Mar / Div / Sep / Wid

If divorced: ❑ Joint Custody ❑ Mother Sole Custody ❑ Father Sole Custody ❑ Legal Documents Provided

If patient is in the care of someone other than a biological parent, please provide legal documentation of guardianship/legal custody. ❑ Yes ❑ No

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PARENT/LEGAL GUARDIAN INFORMATION (CONT.)

Is this parent/legal guardian 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:

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

Relationship to patient: ❑ Mother ❑ Father ❑ Legal Guardian ❑ Foster Parent ❑ DCS ❑ Case Worker ❑ Other:____________________________________

Marital status (circle one) Single / Mar / Div / Sep / Wid

INSURANCE INFORMATION

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

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

Is this patient 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

PATIENT PORTAL INVITATION

If your child is under the age of 11 you will receive an invitation at the email you provided to sign up for a patient portal account.

If your child is between the ages of 11-17 and you would like to be invited to our Patient Portal, please see a patient service representative at the front window, for further information.

IN CASE OF EMERGENCY

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

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/Guardian signature *Date*