MERCYHEALTH Physicians

PATIENT REGISTRATION FORM

First Name _____ MI_____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ ZIP_____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

SS# _____-_____-_____ Sex: **M** **F** Email Address:_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race: ☐ American Indian and Alaska Native ☐ Bi-Racial ☐ Middle Eastern ☐ Hawaiian/Pacific Islander
☐ Black or African American ☐ White/Caucasian ☐ Other ☐ Unknown

Employed: **Y / N** **PT / FT** Employer: _____ Address: _____

Marital Status: **M** **S** **D** **W** **Sep** **SO** Spouse Name_____ Spouse DOB _____

How did you hear about us?_____

Advance Directives: Do you have a Living Will? ☐ Yes ☐ No Preferred Language _____

Emergency Contact: Name _____Relationship _____Phone (____) _____

If the Patient is NOT the Subscriber (person who carries insurance) please provide additional information requested below:

Primary Insurance: _____Subscriber Name: _____ Relationship: _____

DOB: _____ Employed: **Y / N** **PT / FT** Subscriber Name of Employer: _____

Secondary Insurance: _____Subscriber Name: _____Relationship: _____

DOB: _____ Employed: **Y / N** **PT / FT** Subscriber Name of Employer: _____

If you have MEDICARE, please also complete the questions on the back of this form

Primary Care Physician: _____Address: _____ Phone:(____) _____

Referring Physician: (if applicable) _____ Phone (____) _____

Please read and initial each line. If you have questions, please ask us at the front desk for assistance.

1. _____ I have given the office my current and correct insurance information.
2. _____ I understand that I could be ***charged $25 for a missed appointment (no show)*** if a 24-hour notice of cancellation is not given.
3. _____ I understand that I could possibly be discharged from the practice for failing to give 24 hour cancellation notice for three or more scheduled appointments.
4. _____ I understand that my co-payment is due at each visit and a ***$15 administration fee*** will be charged to me, if this agreement is not met.
5. _____ I understand that I may be responsible for charges related to the completion of forms and letters. (Fee schedule will be provided by the office)

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process the claim. I also request payment of insurance benefits either to myself or to the party who accept assignment. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

_____ _____

Signature of Person Responsible Date