Mercy Clinics, Inc.
A member of Mercy Medical Center–Des Moines

FOSTER CHILD PATIENT INFORMATION

☐New ☐ Established

Chart ID________________

☐ Legal Papers on file

*** All foster children will be registered on or moved to their own account ***

FOSTER CHILD PATIENT

FULL Legal Name	Primary Language	Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Lat ☐Other
Last		Referring Physician
First		Primary Physician
Middle	Race	Alternate Name (Preferred, Nickname)
Social Security Number		Student Status ☐Not a student ☐Full-time ☐Part-time
Date of Birth	☐Male ☐Female	Home (Landline)
Address		☐ I do not wish to provide my address, please register patient utilizing the DHS address. / **Dept. of Human Services River Place 2309 Euclid Ave Des Moines, IA 50310**
City	State / Zip Code	
DHS Case Worker		Phone
DHS Office County		Phone

Emergency Contact (person NOT living with patient to contact)

Name	Relationship to patient	Phone

SIBLINGS

Please list below all siblings under the age of 18 who live at the same address as the patient listed above.

Name	☐Male ☐Female	DOB	SS#
Name	☐Male ☐Female	DOB	SS#
Name	☐Male ☐Female	DOB	SS#

CAREGIVER/ FOSTER PARENT OR CURRENT GUARDIAN ◇ WHO THE PATIENT LIVES WITH

FULL Legal Name	Preferred Language	Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Lat ☐Other
Last		Race
First		Alternate Name (Preferred, Nickname, Maiden)
Middle		Date of Birth
Address		Marital Status M S D W
City		☐Male ☐Female
State		*Check preferred contact number* ☐Home (Landline)
Zip Code		☐Cell
Employer		☐Work

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

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 to the best of my knowledge.

X

Signature Date

Clinic use only Updated/Reviewed Date_________ Date _________ Date_________ Date_________

OTHER

How did you hear about Mercy Clinics? ☐Friend ☐ Radio ☐ Family Member ☐Physician ☐Print Advertisement ☐ Phone Book ☐Internet Ad/Search ☐ Television Commercial ☐Other ______________

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