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

PEDIATRIC PATIENT INFORMATION

Chart ID_____

☐New ☐ Established

PATIENT

*** Anyone 18 years or older will be considered an adult and placed on their own account ***

FULL Legal Name	Preferred Language	Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Lat ☐Other
Last		Referring Physician
First		Primary Physician
Middle	Race	Alternate Name (Preferred, Nickname)
Social Security Number		☐Male ☐Female
Date of Birth		Student Status ☐Not a student ☐Full-time ☐Part-time
Address		Home
City	State	Zip Code
Mother's Name	Date of Birth	Does patient live with mom? ☐Yes ☐No
Father's Name	Date of Birth	Does patient live with dad? ☐Yes ☐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	☐Male ☐Female	DOB	SS#
Name	☐Male ☐Female	DOB	SS#
Name	☐Male ☐Female	DOB	SS#

PARENT OR GUARDIAN ◇ WHO THE PATIENT LIVES WITH

FULL Legal Name	Preferred Language	Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Lat ☐Other
Last		Alternate Name (Preferred, Nickname, Maiden)
First		Social Security Number
Middle	Race	Date of Birth
Address		Marital Status M S D W ☐Male ☐Female
City		Student Status☐ Not a student ☐Full-time ☐Part-time
State		*Check preferred contact number* ☐Home (Landline)
Zip Code	Spouse's Name	☐Cell
Employer		☐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? ☐Friend ☐ Radio ☐ Family Member ☐Physician
☐Print Advertisement ☐ Phone Book ☐Internet Ad/Search ☐ Television Commercial ☐Other _____