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

ADULT PATIENT INFORMATION

☐New ☐ Established Chart ID________________

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

PATIENT

FULL Legal Name	**Preferred Language**	**Ethnicity**	☐Hispanic/Latino ☐Not Hispanic/Lat ☐Other
Last		Referring Physician	
First		Primary Physician	
Middle	Race	Alternate Name (Preferred, Nickname, Maiden)	
Social Security Number		Marital Status M S D W	☐Male ☐Female
Date of Birth		Student Status ☐Not a student ☐Full-time ☐Part-time	
Address		*Check preferred contact number*	
City	State	☐Home (Landline)	
Zip Code		☐Cell	
Employer		☐Work	

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.**

SPOUSE

FULL Legal Name	**Preferred Language**	**Ethnicity**	☐Hispanic/Latino ☐Not Hispanic/Lat ☐Other
Last		Race	
First		Alternate Name (Preferred, Nickname, Maiden)	
Middle		Social Security Number	
Address		Date of Birth	☐Male ☐Female
City		Student Status☐ Not a student ☐Full-time ☐Part-time	
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.

☐**I have no insurance, please address the bill to:** ☐Patient ☐Spouse	**My Medicare insurance is not prime because:** ☐Patient or spouse employed ☐Disability ☐Other

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 ________________