MERCYONE℠

TOP OF LABEL
PATIENT LABEL MUST BE PLACED HERE
LABEL CANNOT BE IN ANY OTHER
LOCATION OR POSITION
BOTTOM OF LABEL

# Patient Information

474187 2/01/19 dp 

**Today's Date**_____

Patient's Name: _____
*First* *Middle* *Last* *Maiden*

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Other

Birth Date: _____ Social Security #:_____ Sex: ❒ M ❒ F

Address: _____
*Street* *City* *State* *Zip Code*

Home Phone: _____ Cell Phone: _____ Work Phone: _____
*Area Code* *Area Code* *Area Code*

Email Address: _____

Preferred Primary Care Provider: _____

**MercyOne Clinic collects this demographic information to ensure high quality health care is provided to all of our patients. Thank you.**

| **Race** | | **Ethnicity** | | **Spoken Language** | |
|---|---|---|---|---|---|
| Black | | Hispanic | | English | |
| White | | Non-Hispanic | | Other: | |
| American Indian/Alaskan Native | | | | | |
| Asian | | | | | |
| Native Hawaiian/Pacific Islander | | | | | |

Multiracial: ❑ Alaskan Native/American Indian ❑ Hawaiian.Pacific Islander ❑ Asian
❑ Black/African Americaxn ❑ Unknown ❑ Declined

**Patient's Employer Information**

Name of Employer: _____ Status: ❒ Full-Time ❒ Part Time

Occupation: _____ Date of Employment:_____

Employer's Address: _____

**Spouse Information**

Name: _____ Date of Birth:_____

Social Security #:_____ Telephone: _____

Address: _____
*Street* *City* *State* *Zip Code*

Employer: _____ Work Number: _____

**PLEASE COMPLETE OTHER SIDE**

MERCYONE SM

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# Patient Information

474187 2/01/19 dp 

**If patient is under the age of 18 please complete**

Father's Name _____ Date of Birth _____
Social Security # _____ Marital Status _____ Work Phone _____
Address _____ Home Phone _____
Employer _____
Mother's Name _____ Date of Birth _____
Social Security # _____ Marital Status _____ Work Phone _____
Address _____ Home Phone _____
Employer _____

**Nearest Relative or Person to Notify in Case of an Emergency**

Name _____ Phone _____

Relationship _____

## Insurance Form

**Patient's Name** _____ **DOB** _____

Relationship to Policy Holder: *(Examples: Husband/Wife, Son/Daughter, Stepchild, Mother/Father)* _____

**Primary Insurance**

Name of Insurance Company _____
Effective Date _____ Primary Care Physician _____
Policy # _____ Group # _____ Pre-certification? ❒ Procedure ❒ Hospitalization
Policy Holder's Name _____ MALE / FEMALE
Address _____ Phone # _____
*Street City State Zip*
Birth Date _____ Social Security # _____
Policy Holder's Employer _____ Hire Date _____ Status ❒ PT ❒ FT
Address _____ Phone # _____
*Street City State Zip*

**Secondary Insurance**

Name of Insurance Company _____
Effective Date _____ Primary Care Physician _____
Policy # _____ Group # _____ Pre-certification? ❒ Procedure ❒ Hospitalization
Policy Holder's Name _____ MALE / FEMALE
Address _____ Phone # _____
*Street City State Zip*
Birth Date _____ Social Security # _____
Policy Holder's Employer _____ Hire Date _____ Status ❒ PT ❒ FT
Address _____ Phone # _____
*Street City State Zip*

**AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS:** I hereby authorize insurance and/or Medicare payments for services rendered to me, or my dependents, to be paid to MercyOne. I hereby agree to pay MercyOne any and all charges that exceed or that are not covered by my health insurance coverage. I also authorize MercyOne to release all medical information necessary to process my claims.

**Signed:** _____ **Date:** _____