MERCYHEALTH

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**: _____

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:_____

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

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

***If you have MEDICARE, please also complete the following questions below**

MEDICARE QUESTIONAIRE

1.) Are you receiving Black Lung Benefits (BL)? Yes No
2.) Are the services to be paid by a government research program? Yes No
3.) Are you entitled to benefits through the Department of Veterans Affairs (DVA)? Yes No
4.) Was the illness/injury due to a work-related accident/condition? Yes No
5.) Are you entitled to Medicare based on Age? Yes No
6.) Are you entitled to Medicare based on Disability? Yes No
7.) Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)? Yes No

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 Rev 7-09/11-09/9-11/12-12/01-17