

**MERCY MEDICAL ASSOCIATES
 PATIENT REGISTRATION FORM**

First Name _____ MI _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ ZIP _____

SS# _____ - _____ - _____ Driver License# _____ Sex M/F Marital Status: _____ Race: _____

Home Phone (_____) _____ Cell Phone (_____) _____ Employed: (Y/N) - (PT / FT / PRN / RET)

Name of Employer: _____ Work Phone (_____) _____

Spouse Name _____ Spouse DOB _____ Spouse Cell (_____) _____

Advance Directives: Do you have a Living Will? Yes ___ No ___

Emergency Contact:

Name _____ Relationship _____

Home Phone (_____) _____ Cell (_____) _____ Work (_____) _____

Insurance Information:
Primary Insurance: _____ Member ID# _____ Group _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Name of Employer: _____ Employment Status: (PT / FT / PRN / RET)

Secondary Insurance: _____ ID# _____ Group _____

Subscriber Name: _____ Relationship: _____ DOB: _____

Name of Employer: _____ Employment Status: (PT / FT / PRN / RET)

Additional Information:

Name of Primary Care Physician: _____ Phone: _____

Referring Physician (if applicable) _____ Office Phone (_____) _____

Please read and initial each line. If you have questions, please ask us at the front desk for assistance.

1. _____ I have given the office my current and correct insurance information.
2. _____ I understand that I could be **charged \$25 for a missed appointment (no show)** if a 24-hour notice of cancellation is not given.
3. _____ I understand that I could possibly be discharged from the practice for failing to give 24 hour cancellation notice for three or more scheduled appointments.
4. _____ I understand that my co-payment is due at each visit and a **\$15 administration fee** will be charged to me, if this agreement is not met.

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

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