

TODAY'S DATE	FAMILY DOCTOR	EMAIL ADDRESS
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**PATIENT INFORMATION – PLEASE PRINT**

LAST NAME		FIRST NAME		MI	HOME PHONE	WORK PHONE	CELL PHONE
STREET ADDRESS			SPOUSE (if applicable)		DAYTIME PHONE NUMBER		
CITY	STATE	ZIP	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> DIV <input type="checkbox"/> SEP	SEX <input type="checkbox"/> M <input type="checkbox"/> F	PATIENT'S DATE OF BIRTH		
EMPLOYER NAME		ADDRESS			PATIENT'S SOCIAL SECURITY NUMBER		
<i>IF PATIENT IS A CHILD:</i> FATHER'S NAME (emergency contacts)		FATHER'S WK PHONE	MOTHER'S NAME		MOTHER'S WK PHONE		

**GUARANTOR (PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT)**

LAST NAME		FIRST NAME		MI	HOME PHONE	WORK PHONE	CELL PHONE
STREET ADDRESS			RELATIONSHIP TO PATIENT: <input type="checkbox"/> Self, <input type="checkbox"/> Spouse, <input type="checkbox"/> Parent, <input type="checkbox"/> Other		DAYTIME PHONE NUMBER		
CITY	STATE	ZIP	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH			
EMPLOYER NAME		ADDRESS			<b>GUARANTOR SOCIAL SECURITY NUMBER</b>		

**PRIMARY INSURANCE #1      INSURANCE INFORMATION      SECONDARY INSURANCE #2**

INSURANCE COMPANY		PHONE	INSURANCE COMPANY		PHONE
ADDRESS			ADDRESS		
CITY / STATE / ZIP			CITY / STATE / ZIP		
I.D. NUMBER			I.D. NUMBER		
GROUP NAME OR NUMBER		INSURED'S EMPLOYER	GROUP NAME OR NUMBER		INSURED'S EMPLOYER
INSURED'S LAST NAME		FIRST NAME	INSURED'S LAST NAME		FIRST NAME
ADDRESS		DATE OF BIRTH	ADDRESS		DATE OF BIRTH
CITY / STATE / ZIP			CITY / STATE / ZIP		
Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent		EMPLOYER INS PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	Patient's Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent		EMPLOYER INS PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO

**OTHER FAMILY MEMBERS TO BE SEEN AT THIS OFFICE**

Last Name	First Name	Social Security #	Date of Birth	Primary Insurance
Last Name	First Name	Social Security #	Date of Birth	Primary Insurance
Last Name	First Name	Social Security #	Date of Birth	Primary Insurance

**EMERGENCY INFORMATION**

<b>NAME - NOT LIVING WITH YOU</b>		RELATIONSHIP	HOME PHONE	WORK PHONE
STREET ADDRESS		CITY / STATE / ZIP		

I agree to guarantee payment for charges incurred for services rendered by MercyCare Community Physicians, Inc. I understand that payment is due at the time of service. If I have insurance, whether through a governmental program or private insurance company, I hereby authorize direct payment of insurance benefits otherwise due or payable to me or on my behalf to MercyCare Community Physicians, Inc. I understand that I am responsible for, and agree to pay, all charges not covered by insurance and any applicable co-payments or deductibles.

PATIENT / RESPONSIBLE PARTY SIGNATURE	DATE
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**HOW DID YOU HEAR ABOUT US?**     Friend/Relative (Name \_\_\_\_\_)     Yellow Pages     Referral Line  
Please complete. Thank you!     Website     Mail     Radio     Billboard     Newspaper     Other \_\_\_\_\_