



MERCY CHILDREN'S CLINIC

PATIENT REGISTRATION FORM

A. PATIENT INFORMATION (required)

PLEASE PRINT			Patient SSN#	
Last Name		First Name		Middle Name
Street Address				Home Phone ()
City	State	Zip	Race <input type="checkbox"/> Asian / Pacific <input type="checkbox"/> Black / African-American	
Birth Date (mm/dd/yy)	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> White / European <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Other	
Brother/Sister's Name		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Patient at MCC? <input type="checkbox"/> Yes
Brother/Sister's Name		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Patient at MCC? <input type="checkbox"/> Yes
Brother/Sister's Name		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Patient at MCC? <input type="checkbox"/> Yes
Brother/Sister's Name		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Patient at MCC? <input type="checkbox"/> Yes
Brother/Sister's Name		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Patient at MCC? <input type="checkbox"/> Yes

B. PARENTS / GUARDIAN (required)

FATHER'S INFORMATION

Last Name		First Name		Middle Name
Address				Home Phone ()
City	State	Zip	Work Phone ()	
Birth Date (mm/dd/yy)	SSN		Mobile Phone ()	
Employer	Occupation		E-Mail	

MOTHER'S INFORMATION

Last Name		First Name		Middle Name
Address				Home Phone ()
City	State	Zip	Work Phone ()	
Birth Date (mm/dd/yy)	SSN		Mobile Phone ()	
Employer	Occupation		E-Mail	

GUARDIAN'S INFORMATION (if applicable)

Last Name		First Name		Middle Name
Address				Home Phone ()
City	State	Zip	Work Phone ()	
Birth Date (mm/dd/yy)	SSN		Mobile Phone ()	
Employer	Occupation		E-Mail	

WHO IS FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT?

Father Mother Guardian Other

Today's Date

Please Complete Sections on Other Side >>>>

PATIENT REGISTRATION FORM (continued)

C. INSURANCE INFORMATION (required)	No insurance? Please check here <input type="checkbox"/> and see below.
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PRIMARY INSURANCE (copy of card must be on file at our office)

1st Insurance Name	Name of Subscriber
Subscriber Birth Date (mm/dd/yy)	Subscriber SSN
Relationship of Patient to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Other	

In accordance with our benefits, at each office visit, we will be responsible to pay a co-pay of \$_____ **OR** a percentage of _____ %

SECONDARY INSURANCE (copy of card must be on file at our office)

2nd Insurance Name	Name of Subscriber
Subscriber Birth Date (mm/dd/yy)	Subscriber SSN
Relationship of Patient to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Other	

PLEASE NOTE: Any time you receive a new or updated insurance card, we must have a copy of it in order to properly bill your insurance.

D. SELF-PAY INFORMATION

If you do not have insurance to cover healthcare visits to Mercy Children’s Clinic, do not worry, we are here to help! We have an additional form that you will need to fill out. If you have not received this form already, please obtain one from the front desk.

One of our missions is to make healthcare financially accessible. We will take care of you and your children no matter the circumstances. Allow us to work with you...it’s what we love to do!

E. EMERGENCY CONTACT (other than parent or guardian)

Relationship of Patient to Subscriber <input type="checkbox"/> Brother / Sister <input type="checkbox"/> Uncle / Aunt <input type="checkbox"/> Grandparent <input type="checkbox"/> Family Friend <input type="checkbox"/> Other:		
Last Name	First Name	Middle Initial
Home Phone ()	Work Phone ()	Mobile Phone / Pager ()

F. HOW DID YOU HEAR ABOUT US? (requested)
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Please let us know how you found out about our clinic by selecting one of the boxes below:
 Church Family / Friend Newspaper Phone Book Physician’s Office WAY-FM Other:

Do you know that we are providers for TN BCBS, Aetna, United Healthcare, PHCS and many other commercial insurance companies and networks. Help us grow by letting your friends and family know that we are providers for their insurance companies. One of the ways that we continue to be able to provide care to those without insurance and why we continue to take 2 times the normal amount of TennCare patients is partly due to the fact that we can bill for and collect monies from commercial insurance companies. Thanks for your referrals!

G. AUTHORIZATION (required)

I am the patient and I authorize that treatment be given to me. Furthermore...

The patient is a minor and I authorize that treatment be given to him/her. Furthermore...

I voluntarily authorize the release of medical information, including any drug/alcohol, mental health and HIV/AIDS information contained therein, for the purpose of determining insurance and other benefits payable. I also consent that the payment of authorized insurance benefits be made on their behalf directly to Mercy Health Services, Inc (d.b.a. Mercy Children’s Clinic) for any medical or surgical services furnished. In the event that medical insurance (if applicable) does not pay for the service rendered, I agree to pay and therefore settle any outstanding balances with Mercy Children’s Clinic.

Signature:	Date:
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Relationship (if patient is a minor) <input type="checkbox"/> Father / Mother <input type="checkbox"/> Grandparent <input type="checkbox"/> Guardian <input type="checkbox"/> Other:
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