Mercy Clinic Children's Infectious Disease & Rheumatology
Mercy Clinic Kids GI, Complex Care
REGISTRATION FORM

Date of Appointment: ___________________

PATIENT DEMOGRAPHICS

Name: ____ SSN: _________________________________

Sex: ☐ Male ☐ Female Birth date: ______________ Nickname/Preferred Name: ______________________________________

Patient Address

Address: ____

____

City: ____

State: _________________ Zip: ______________________

Home phone: _____________________________

Work phone: _____________________________

Cell phone: _____________________________

E-mail: ___________________________________

Best Contact # for Appointment Reminders:____

Preferred Communication Method: ☐ Mail ☐ My Mercy

Mother/Guardian name: ____________________________________

DOB:_______________________

Home phone:______________________________

Work phone:______________________________

Cell phone:______________________________

Father/Guardian name:______________________________________

DOB:_____________________

Home phone:______________________________

Work phone:______________________________

Cell phone:______________________________

☐ Married ☐ Separated ☐ Divorced ☐ Life partner

Biological siblings (list names):

____

____

PRIMARY CARE PROVIDER INFORMATION

Pediatrician: ____

Phone number:____

Referring doctor's name: ____________________________________

Referring doctor's phone number: ______________________________

RESPONSIBLE PARTY/GUARANTOR

Name: ____ DOB: ____________ SSN:_____________________

Address: ____

____

City: ____

State: _________________ Zip: ________________Phone: ______________________________

Relationship to Patient: ____

EMERGENCY CONTACT INFORMATION (Other than parents)

Name: ____ Home phone: _________________________

Address: ____ Work phone: _________________________

____ Cell phone: __________________________

____ Relationship to Patient: __________________

City: ____ State: ____________________Zip:_________

SUBSCRIBER ACCOUNT INFORMATION

Insurance Coverage (**Medicaid Patients: Subscriber is ALWAYS the patient**)

Insurance Name:__________________________________

Insurance Effective Date:___________________________

Subscriber Name: _________________________________

Subscriber DOB:__________________________________

Subscriber Employer:_______________________________

Secondary Insurance Name:______________________

Secondary Insurance Effective Date:________________

Secondary Subscriber Name:_____________________

Secondary Subscriber DOB________________________

Secondary Subscriber Employer:___________________