

ADULT PATIENT INFORMATION

New Established

Chart ID _____

*** Anyone 18 years or older will be considered an adult and placed on their own account ***

PATIENT

Legal Name (Please provide full legal name below)

Last _____ Referring Physician _____
 First _____ Primary Physician _____
 Middle _____ Alternate Name (Preferred, Nickname, Maiden Name) _____
 Social Security Number _____ Marital Status M S D W Male Female
 Date of Birth _____ Student Status Not a student Full-time Part-time
 Address _____ *Check preferred contact number*
 City _____ State _____ Home (Landline)
 Zip Code _____ Cell
 Employer _____ Work

Emergency Contact (person NOT living with patient to contact):

Name _____ Relationship to patient _____ Phone _____

NOTE

Mercy Clinics, Inc. routinely does family billing (all family member charges appear on one family bill). This bill may be addressed to the person listed below as the subscriber of the primary insurance.

SPOUSE

Legal Name (Please provide full legal name below)

Last _____
 First _____ Alternate Name (Preferred, Nickname, Maiden Name) _____
 Middle _____ Social Security Number _____
 Address _____ Date of Birth _____ Male Female
 City _____ Student Status Not a student Full-time Part-time
 State _____ *Check preferred contact number*
 Home (Landline)
 Zip Code _____ Cell
 Employer _____ Work

Please provide all pertinent information regarding your insurance coverage and present your current insurance card to the receptionist.

I have no insurance, please address the bill to:
 Patient Spouse

My Medicare insurance is not prime because:
 Patient or spouse employed Disability Other

INSURANCE

Primary Insurance _____ Person Carrying Ins. _____

Effective Date _____ Ins ID# _____ Date of Birth _____
 Group # _____ Relation to Patient _____ SS# _____

Secondary Insurance _____ Person Carrying Ins. _____

Effective Date _____ Ins ID# _____ Date of Birth _____
 Group # _____ Relation to Patient _____ SS# _____

By signing this, I verify that this information is correct and that I am ultimately financially responsible for any charges incurred.

X

Signature _____

Date _____

Clinic use only Updated/Reviewed Date _____ Date _____ Date _____ Date _____

OTHER

How did you hear about Mercy Clinics?
 Friend Radio Family member Physician
 Print Advertisement Phone Book Internet Ad/Search Television Commercial Other

Patient's full name: _____
 Birthdate: _____ Today's Date: _____

Patient Medical History:

Doctor who requested today's appointment:
 (first and last name) _____

Who is your Family doctor?
 (first and last name) _____

Reason you are seeing the doctor and your current symptoms? _____

Medication Allergies: _____

Any other allergies (latex, rubber, etc.)? _____

Current medications (prescription and over the counter): _____

Personal History of illness (do you experience any of the following?)

- | | | | | |
|-----------------------------------|---|---|--|---|
| General: | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Fatigue |
| | <input type="checkbox"/> Chills | <input type="checkbox"/> Trouble Sleeping | | |
| Head: | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Sinus Problems | |
| Cardiovascular: | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Chest pain |
| Respiratory: | <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of Breath? | <input type="checkbox"/> Asthma | |
| Gastrointestinal: | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Colitis | <input type="checkbox"/> Change in Bowel Habits |
| | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Stomach Pain |
| | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| Genitourinary: | <input type="checkbox"/> Painful/burning on urination | | <input type="checkbox"/> Kidney Disease | |
| Musculoskeletal: | <input type="checkbox"/> Arthritis/joint pain | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Back pain | |
| Hematologic/
Oncologic | <input type="checkbox"/> Cancer | <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Anemia | |
| | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phlebitis | |
| Endocrine: | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid | | |
| Neurologic | <input type="checkbox"/> Headache | <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | |
| Psychiatric: | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chemical dependency | |

Have you had a colonoscopy? _____ If so, when _____

Have you had a mammogram? _____ If so, when _____

Surgeries and Hospitalizations:

- | | |
|---------------------|---------------------|
| 1. _____ Year _____ | 4. _____ Year _____ |
| 2. _____ Year _____ | 5. _____ Year _____ |
| 3. _____ Year _____ | 6. _____ Year _____ |

Family History:

Is there any history of the following diseases in your family? If yes, indicate which relative.

<u>DISEASE</u>	<u>WHICH RELATIVE</u>	<u>DISEASE</u>	<u>WHICH RELATIVE</u>
Cancer (type) _____	_____	Heart Disease (type) _____	_____
Blood Clots _____	_____	Bleeding tendency _____	_____
Reaction to Anesthesia _____	_____		

Social History:

Married Widowed Single Divorced Other _____ Occupation: _____

Tobacco use: No If quit, how long ago did you smoke? _____ Yes - How much _____ Year began _____

Caffeine use: No Yes - How much _____

Alcohol use: No Yes - How much _____

Drug Use: No Yes - How often _____
 (i.e: marijuana, cocaine, heroin, methamphetamine)

Do you have a Living Will/Advanced Directives? Yes No

Do we have a copy? Yes No

Alternative Communications Request Form
(alternative ways to communicate with Mercy Clinic patients)

Patient Name _____

Complete those that apply:

I give permission to be contacted at any of the following phone numbers regarding messages or results for myself or my minor children:

- home _____
- work _____
- cell _____
- fax _____
- other (please specify) _____

I give permission to (please mark all that apply):

- Leave message/result on answering machine
(messages will not be left on an unidentified answering machine)
- Leave message/result with a family member
Please specify family member _____
Relationship _____
Phone number of family member if not living with you _____

I give permission for the following person(s) to discuss my health information:

This form of communication will be used as the standard form of communication until I revoke this in writing.

Patient name _____ Date of Birth _____

Patient/Guardian Signature _____

Date signed _____ Staff initials _____

Date Updated _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

_____ (insert individual name) acknowledge that I received a copy of Mercy Clinic, Inc, Notice of Privacy Practices dated _____ (Insert date of Notice of Privacy Practices).

(Individual's signature or initials)

(Personal representative of individual, if individual is unable to sign)

(Date)

(Witness signature)

Individual (or personal representative of the individual) did not sign the acknowledgement for the following reason:

(check (√) _ one of the reasons below)

- Individual refused
- Individual refused, stating that he/she has already signed an acknowledgement
- Individual unable to sign because of medical condition
- There was not a personal representative of the individual available to sign
- Other (explain) _____

Witness

Date