



Primary Care Physician _____

<i>Patient Information</i>						
Social Security Number	Last Name	First Name			MI	
Address		City		State	Zip	
Home Phone ()	Date of Birth / /	Sex Male	Female	Student Status Non-Student	Full-time	Part-time
Mother's Maiden Name			Allergies			

<i>Family Information</i>			
Mother's Full Name		Father's Full Name	
Parents' Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
If divorced, do both parents have custody and/or visitation rights? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, please provide court documentation regarding the denial of parental rights.			
<i>Siblings</i>			
Full Name(s) of Siblings:	Date of Birth		Sex
_____	____/____/____		<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	____/____/____		<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	____/____/____		<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	____/____/____		<input type="checkbox"/> Male <input type="checkbox"/> Female

<i>Responsible Party (Who is responsible for the remaining balance on this account?)</i>						
Social Security Number	Last Name	First Name			MI	
Address		City		State	Zip	
Home Phone ()	Work Phone ()	Cell Phone ()	Name of Employer			
Employer's Address		City		State	Zip	
Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Relation to Patient	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian		<input type="checkbox"/> Other			

<i>Primary Insurance</i>			
Insurance Company Name		Subscriber's Name	
Subscriber's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		Subscriber's DOB / /	Subscriber's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber's Employer	Patient's ID #	Group #	Copay Amount
Employer Address		City	State Zip

Insurance Company Address		City	State	Zip
Secondary Insurance				
Insurance Company Name		Subscriber's Name		
Subscriber's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		Subscriber's DOB / /		Subscriber's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Subscriber's Employer		Patient's ID #	Group #	Copay Amount
Employer Address		City	State	Zip
Insurance Company Address		City	State	Zip

Emergency Contact Information

Contact Name:

Relationship to Patient

Spouse Parent/Guardian Other

Contact Phone:

() _____

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I hereby authorize the release of all applicable medical information, including without limitation copies of all records and test results produced to the designated attending, referral and/or follow-up physicians and such, other health care practitioners or organizations who/which will be providing subsequent monitoring, care or treatment in connection with care provided by any St. John's Mercy Health Care facility. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third-party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I understand that any billing or financial information will be available to other St. John's Mercy Health Care physicians. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to the physician and/or clinic. I further agree that a photocopy or scanned copy of this document is to be considered as valid as the original. The information on this form is true to the best of my knowledge. I hereby authorize the release of all applicable medical information, including without limitation copies of all records and test results produced to the designated attending, referral and/or follow-up physicians and such, other health care practitioners or organizations who/which will be providing subsequent monitoring, care or treatment in connection with care provided by any St. John's Mercy Health Care facility. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third-party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I understand that any billing or financial information will be available to other St. John's Mercy Health Care physicians. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to the physician and/or clinic. I further agree that a photocopy or scanned copy of this document is to be considered as valid as an original.

PATIENT SIGNATURE: _____

DATE: _____

GUARANTOR SIGNATURE: _____

DATE: _____