MERCY UROLOGY CLINIC — DEMOGRAPHIC SHEET

DATE

PATIENT DEMOGRAPHICS (PROVIDE PHOTO ID TO SCAN)

FULL NAME (FIRST MI LAST)	PREFERRED CONTACT METHOD ❑ E-mail ❑ Mail ❑ Phone	PREFERRED PHONE NUMBER ❑ Home ❑ Work ❑ Cell ❑ Other:
ADDRESS	DATE OF BIRTH	WORK STATUS EMPLOYER
CITY	SSN	PHARMACY
STATE, ZIP CODE	MARITAL STATUS GENDER	PRIMARY CARE PROVIDER
HOME PHONE	RACE ETHNICITY ❑Other ❑Hispanic or Latino	REFERRAL SOURCE ❑Provider ❑Friend ❑Hospital ❑Mail ❑Newspaper ❑Radio ❑Employer ❑TV ❑Relative ❑Internet ❑Other:
CELL PHONE	FIRST LANGUAGE	
WORK PHONE	E-MAIL ❑None	

GUARANTOR (FINANCIAL RESPONSIBLE)

PATIENT'S RELATION TO GUARANTOR ❑Self ❑Husband ❑Wife ❑Child ❑Parent ❑Other		HOME PHONE
FULL NAME	DATE OF BIRTH	CELL PHONE
ADDRESS ❑Same as above	SSN	WORK PHONE
CITY	EMPLOYER	WORK STATUS ❑Retired ❑Student ❑ Full-time ❑Part-time ❑Unemployed
STATE, ZIP CODE	E-MAIL ❑*None*	

INSURANCE (PROVIDE CARD(S) TO SCAN)

PRIMARY NAME	SECONDARY NAME
GROUP #	GROUP #
POLICY #	POLICY #
EMPLOYER PLAN	EMPLOYER PLAN
PATIENT'S RELATION TO INSURED ❑Self ❑ Husband ❑Wife ❑Child ❑Parent ❑Other:	PATIENT'S RELATION TO INSURED ❑Self ❑ Husband ❑Wife ❑Child ❑Parent ❑Other:
INSURER'S FULL NAME	INSURER'S FULL NAME
DOB	DOB
HOME PHONE	HOME PHONE

EMERGENCY CONTACT

FULL NAME (FIRST MI LAST)	LANGUAGE
RELATIONSHIP TO PATIENT	HOME PHONE
DATE OF BIRTH	CELL/OTHER PHONE

HEALTH INFORMATION

MAY WE DISCUSS HEALTH INFORMATION WITH ANOTHER PERSON? ❑ No ❑ Yes	RELATIONSHIP TO PATIENT: ❑ Husband ❑Wife ❑Child ❑Parent ❑Other:
IF YES, NAME (FIRST MI LAST):	IF YES, WHAT TYPE: ❑ Billing/Financial ❑ Scheduling/Appointments ❑ Medical/Treatment/Diagnosis
DATE OF BIRTH	DO YOU WANT COPIES OF MEDICAL RECORDS SENT TO YOUR PRIMARY CARE PROVIDER? ❑ *No* ❑ *Yes*

POLICY ACCEPTANCE

	INITIAL
FINANCIAL: *I hereby authorize payment of charges incurred for services rendered at clinic directly to the physician and/or clinic. I realize any non-covered services will be my responsibility.*	
HIPAA: *I acknowledge that I have received or been offered a copy of clinic privacy practice policy.*	
AUTHORIZATION TO RELEASE: *I hereby authorize the physician and/or clinic to release my information and/or records during the course of treatment necessary to process insurance claims and referrals for continuing care.*	

SIGNATURE: ______________________ **RELATIONSHIP :** ______________ **DATE:**____________