Mercy
PROFESSIONAL PRACTICE ASSOCIATES, INC.
A service of Mercy Medical Center–Des Moines

Iowa Diabetes and Endocrinology Center

ADULT PATIENT INFORMATION

☐New ☐ Established Chart ID_____

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

PATIENT

FULL Legal Name	**Preferred Language**	**Ethnicity** ☐Hispanic/Latino ☐Not Hispanic/Lat ☐Other
Last		Referring Physician
First		Primary Physician
Middle	Race	Alternate Name (Preferred, Nickname, Maiden)
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	Email	☐Cell
Employer		☐Work

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

Name Relationship to patient Phone

NOTE **Iowa Diabetes and Endocrinology Center 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

FULL Legal Name	**Preferred Language**	**Ethnicity** ☐Hispanic/Latino ☐Not Hispanic/Lat ☐Other
Last		Alternate Name (Preferred, Nickname, Maiden)
First		Race
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 Iowa Diabetes and Endocrinology Center? ☐Friend ☐ Radio ☐ Family member ☐Physician ☐Print Advertisement ☐ Phone Book ☐Internet Ad/Search ☐ Television Commercial ☐Other _____

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I give permission to discuss medical information with person(s) noted below:

☐ Yes (if yes, please provide name(s)/relationship and phone number(s) below) ☐ No

Name: _____ Phone: _____

Name: _____ Phone: _____

Do we have permission to leave a message on your home/mobile voice mail? ☐Yes ☐ No

Research Information

Our clinic is excited to offer our patients the chance to take part in clinical research trials. By signing below, I allow the clinic to screen my record for research trials. I understand that I still have the right to refuse participation in any trial that is offered to me.

☐ Yes, please screen my chart for research studies.

☐ No, do not screen my chart for research studies.

I have read the Cancellation Policy. ☐ Yes ☐ No (this will be provided at your initial visit)

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment below.

My signature below acknowledges that a copy of the Mercy Professional Practice Associates Notice of Privacy Practices has been made available to me.

Signature: _____ Date: _____
(Patient or Authorized Person)