MANNING REGIONAL HEALTHCARE CENTER
CLINIC • HOSPITAL • RECOVERY CENTER • PLAZA

1550 6th Street
Manning, Iowa 51455
(712) 655-2072
www.mrhcia.com

Demographic Form

Today's Date:		Primary Care Physician:			
PATIENT INFORMATION					
Patient's last name:		First:		Middle:	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ☐ M ☐ F
Street Address:		Mailing address (if different):	City:	St:	Zip:
Social Security number:	Marital status:	Home phone number:	Cell phone number:		
Occupation:	Employer:	Employer address:	Employer phone number:		
INSURANCE INFORMATION					
PLEASE GIVE YOUR INSURANCE CARD TO THE ADMISSION STAFF					
Person responsible for bill:	Birth date:	Address (if different):	Home phone number:		
Occupation:	Employer:	Employer address:	Employer phone number:		
PLEASE INDICATE PRIMARY INSURANCE:					
Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:					
SECONDARY INSURANCE (if applicable):					
Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:					
IN CASE OF EMERGENCY					
Name of 1st Emergency Contact:	Address:	Relationship to patient:	Home phone number:	Work phone number:	
Name of 2nd Emergency Contact:	Address:	Relationship to patient:	Home phone number:	Work phone number:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Manning Regional Healthcare Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date