# SWEDISH CANCER INSTITUTE PATIENT REGISTRATION

Patient Name _____ Male ☐
last first middle initial Female ☐

Mailing Address _____ apt # _____
street

_____
city state zip

Home phone _____ Day/Cell Phone _____ E-mail _____

Marital Status: Single ☐ Married ☐ Separated ☐ Widow/er ☐ Dependent ☐ Domestic Partner ☐

Birthdate ____/__/_____Age_____Social Security#_____

Primary Care Physician _____

Referred by Dr._____ Phone_____
last first

Referrer by Patient/0ther _____ Phone_____
last first

Employed ☐ Retired☐ Not employed ☐ Patient's Employer/School _____ Phone_____

Parents/Spouse/Domestic Partner Name_____

Employer _____ Phone_____

## PRIMARY INSURANCE

Ins. Co. Name _____

Subscriber Name_____

Birthdate__ /___ /_____

Group # _____ ID #_____

Subscriber's Employer _____

Does your insurance carrier require a referral? Yes ☐ No☐

## ANY OTHER INSURANCE

Ins, Co. Name _____

Subscriber Name_____

Birthdate ___/_____/_____

Group # _____ ID# _____

Subscriber's Employer _____

## BILLING INFORMATION

(Complete if person responsible for bill is not the patient)

Name of Person Responsible for Bill _____ Relatlonship _____

Social security # _____ Policy Holder Date of Birth _____/_____/_____

Address if not as above) _____
Street city state zip

Home Phone _____ Employer _____

Work Phone _____ Address _____
Street city state zip

**Legal Next of Kin *REQUIRED*** (Spouse ¯first, if no spouse, then family member) Name: _____

Phone_____ Relationship:_____

**Emergency Notification *REQUIRED*** Name: _____

Phone_____ Relationship:_____

I authorize my insurance benefits to be paid to Swedish Health Services and Swedish Medical Group. I understand I am financially responsible for any balance that my insurance does not pay. I authorize the doctor or insurance company to release any information required for this claim.

Signature_____

Date _____