SWEDISH
MEDICAL GROUP

PATIENT LABEL HERE

REGISTRATION FORM

Patient Information

Last Name	First Name		Middle Name	
Alias or Maiden Name	Sex / Birth Date	Social Security #		Marital Status
Street Address	City	State		Zip Code
Language	Need Interpreter	Ethnicity		Race
Home Phone	Work Phone	Cell Phone		Religion
Employer Name	Employment Status	Retirement Date (if applicable)		Occupation
Emergency Contact Name	Emergency Contact Number		Relationship to the Patient	
Primary Care Provider Name	Primary Care Provider Phone #	Referred? ☐ Yes ☐ No	Referred By Name/Phone #	

Guarantor (Person Responsible for Bill)

Last Name	First Name	Middle Name	Relationship to the Patient	
Alias or Maiden Name	Sex / Birth Date	Social Security #		Marital Status
Street Address	City	State		Zip Code
Language	Need Interpreter	Ethnicity		Race
Home Phone	Work Phone	Cell Phone		
Employer Name	Occupation	Employment Status		

Insurance Information

Primary Insurance

Insurance Company Name	Group Number	Subscriber ID Number		Copay
Subscriber's Name	Social Security Number	Date of Birth	Sex	Relationship to the patient
Subscriber's Employer Name	Subscriber Employment Status	Home Phone		Work Phone

Secondary Insurance

Insurance Company Name	Group Number	Subscriber ID Number		Copay
Subscriber's Name	Social Security Number	Date of Birth	Sex	Relationship to the patient
Subscriber's Employer Name	Subscriber Employment Status	Home Phone		Work Phone

CONSENT TO CARE:
I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that Swedish participates in the training of physicians and other healthcare providers, and I will be told when trainees take part in my care. _____ Initial

NOTIFICATION OF RELEASE FOR PAYMENT:
I understand that the Swedish Medical Group will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions. _____ Initial

FINANCIAL AGREEMENT:
I understand co-payments are due at the time of service. I assign payment from my insurance directly to the Swedish Medical Group. I understand I am financially responsible to the Swedish Medical Group for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills from the laboratory, radiology and other specialized services. _____ Initial

RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES:
I have received a copy of the Swedish Medical Group **Notice of Health Information Practices** which provides information about how my health information may be used and disclosed.

I have read the above and understand its contents:

Date: _____ Patient Signature: _____

☐ Data entered into Epic
☐ Insurance card scanned
☐ Driver's license/picture ID scanned

Parent or Guardian: _____

Medicare

Medicare Number: _____ Part A ☐ Part B ☐

MEDICARE QUESTIONNAIRE - Required for all Medicare Patients

MSP General Information

Are your (patient's) Medicare benefits based on age? ..... Yes / No
Are you employed? ..... Yes / No
Is your spouse employed? ..... Yes / No
If yes, are you covered by an employer's heal plan? Yes / No .....does the employer have 20 or more employees? Yes / No
Are you or your spouse retired? Neither / Patient / Spouse. *If yes, spouse's name* _____

patient's retirement date: _____ *spouse's retirement date:* _____

Are you entitled to Medicare because of end stage renal disease? ..... Yes / No
Are you entitled to Medicare because of disability, other than ESRD? ..... Yes / No
Has the department of veterans affairs (DVA) authorized to pay for care at this facility? ..... Yes / No
Are you entitled to benefits under the Federal Black Lung Program? ..... Yes / No
Is this illness/injury due to a work related accident? ..... Yes / No
Is this illness/injury due to a third party responsible related accident? ..... Yes / No
Are services to be paid for by a government research program? ..... Yes / No

Information supplied by: _____ Relationship to patient: _____

This sheet is intended for prescreening purposes only. If you have answered yes to any of the above questions or are receiving Medicare benefits due to Disability or ESRD more information will be required to process your registration.

Accident/Injury Claim

Circle One: Work / Auto / Other

Insurance Company Name: _____ Claim #/Policy#: _____

Date of Injury / Accident: _____ What state did it occur in?: _____

Claim Manager/Adjuster Name: _____ Phone Number: _____

Employer at time of injury (if work related): _____ Phone Number: _____

Briefly describe how injury occurred: _____