

## PEDIATRIC REGISTRATION FORM

## Patient Information

| i atient inionnation  |  |   |   |   |  |  |   |  |  |
|---|--|---|---|---|--|--|---|--|--|
| Last name   | First nar  | ne  |   |   |  | Middle Name  |   |  |  |
| Alias or Maiden Name  | Sex  |   |   | Birth Date  |  | Social Security #  | curity #  |  |  |
| Street Address  | City   |   |   |   | State  |  | Zip Code  |  |  |
| Language  | Need Int   | terpret   | er  | Ethnicity   |  |  |   | Race   |  |
| Home Phone  | Work Ph  | ione  |   | Cell Phone  | Cell Phone   |  |   |  |  |
| Emergency Contact Name & Relationship   | ☐ Patien   | 101 19 1  | Mother  | ☐ Patient [   | Patient  Mother Father   |  |   |  |  |
|   |  | 23  |   |   |  |  |   |  |  |
| If patient is under the age of 18 name of Parent(s) or Guardian(  | s) living at   | this ac   | ddress  |   |  |  |   |  |  |
| Primary Care Physician  | Referring  | g Phys  | ician   | Referring Phy   | rring Physician Clinic and phone number  |  |   |  |  |
| Guarantor (Person Responsible fo  | r Bill)  |   |   |   |  |  |   |  |  |
| Last name   | First nar  | ne  |   | Middle  |  | Name   |   |  |  |
| Alias or Maiden Name  | Sex  | Birth   | Date  | Social Securit  | ty #   |  | Marital Status                                  |  |  |
| Street Address  | City   |   |   | -1  | State  |  | Zip   | Code   |  |
| Language  | Need Int   | terpret   | er  | Ethnicity   |  |  | Vi.   | Race   |  |
| Home Phone  | Work Ph  |   |   | Cell Phone  |  |  |   |  |  |
| Employer Name   | ☐ Patier<br>Occupat  |   | Mother  | ☐ Patient   | Patient □ Mother □ Father  |  |   |  |  |
| Insurance Information Primary Insurance Insurance Company Name  | Group N  | lumber  |   | Subscriber ID   | bscriber ID Number   |  |   | Copay  |  |
| Subscribers Name  | Social S   | ecurity   | Number  | Date of Birth   | Date of Birth  |  |   | Relationship to Patient                                    |  |
| Subscribers Employer Name   | ployer Name  |   |   |   | Subscribers Work Phon  |  | hone  |  |  |
| Secondary Insurance   |  |   | '   |   |  | <u>'</u>   |   |  |  |
| Insurance Company Name  | Group N  | lumber  |   | Subscriber ID Number  |  | r  | Copay   |  |  |
| Subscribers Name  | Social S   | ecurity   | Number  | Date of Birth   |  |  |   | Relationship to Patient                                    |  |
| Subscribers Employer Name   |  |   |   | Subscribers Home Phone  |  |  | Subscribers Work Phone                          |  |  |
| CONSENT TO CARE:  I consent to the plan of care proposed by the providers i accept or refuse this plan of care. I will ask for any info participates in the training of physicians and other health NOTIFICATION OF RELEASE FOR PAYMENT I understand that the Swedish Medical Group will discle companies and any liable third party payers. I understant including testing and/or treatment for HIV/AIDS, sexual FINANCIAL AGREEMENT:  I understand co-payments are due at the time of service. I responsible to the Swedish Medical Group for the charges to the bill from my provider, I may also receive separate RECEIPT OF NOTICE OF HEALTH INFORMA I have received a copy of the Swedish Medical Group Not used and disclosed.  I have read the above and understand its contents: | ormation I heare prove F: ose any did that this last the second of the s | I want<br>viders<br>iagnos<br>s disc<br>iitted<br>aymer<br>by in<br>the I | to have about my medical cand I will be told when trains and pertinent information to losure, unless expressly limited diseases, substance abuse, or at from my insurance directly issurance and that those charges aboratory, radiology and other TICES: | are and will mees take part in the extent read by me in whether the extent read by the interest of the Swedish is are due withing specialized services. | ake my<br>n my c<br>equired<br>riting,<br>condition<br>Medican<br>30 da<br>rvices. | wishes known. I urare.  I to assure payment f will extend to all aspons.  I Group. I understarys of invoice. I understarys of invoice. | nitia<br>rom<br>pects<br>nitia<br>nd I<br>ersta | insurance of treatment  am financially nd that in addition |  |
| Date:   |  | P   | atient Signature:   |   |  |  |   |  |  |
| <ul> <li>□ Data entered into Epic</li> <li>□ Insurance card scanned</li> <li>□ Drivers license/picture ID scanned</li> </ul>  | Parent or Guardian:  |   |   |   |  |  |   |  |  |