SWEDISH

ADULT REGISTRATION FORM

PATIENT INFORMATION

Last Name (Legal)	First Name, Middle Name (Legal)	Preferred Name	
Previous Name(s)	Social Security Number	Sex ☐ Female ☐ Male ☐ Other	Date of Birth
Gender Identity ☐ Female ☐ Transgender Female / Male to Female ☐ Other / Non-Binary ☐ Male ☐ Transgender Male / Female to Male ☐ Prefer Not to Disclose	Patient Preferred Pronouns ☐ She / Her ☐ He / Him ☐ They / Them	Primary Care Provider Name	Primary Care Provider Number
Address	City	State	Zip Code

Home Phone	Work Phone	Mobile Phone	E-Mail

Religion	Marital Status	Ethnicity ☐ Hispanic or Latino ☐ Decline to Answer ☐ Non-Hispanic or Latino	Race ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Decline to Answer

Preferred Language (to discuss healthcare)	Would you like to use an interpreter? ☐ Yes ☐ No	Communication Assistance ☐ Hearing ☐ Speech ☐ Vision ☐ Other
Employer Name	Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired	Occupation
Emergency Contact Name	Emergency Contact Number	Emergency Contact Relationship to Patient

RESPONSIBLE PARTY (Legal Guardian / Healthcare Durable Power of Attorney)

Please provide guardianship court order or healthcare durable power of attorney document
(*Healthcare Durable Power of Attorney should only be contacted if the patient is/becomes unable to make his/her own decisions*)

Last Name	First Name	Middle Name	
Home Phone	Social Security Number	Sex ☐ Female ☐ Male ☐ Other	Date of Birth
Address	City	State	Zip Code

PRIMARY INSURANCE

Insurance Company Name	Group Number		Subscriber ID Number	
Subscribers Name (Policy Holder)	Social Security Number	Date of Birth	Sex ☐ Female ☐ Male ☐ Other	Relationship to Patient
Subscribers Employer Name	Subscriber Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired		Subscriber Phone Number	

SECONDARY INSURANCE

Insurance Company Name	Group Number		Subscriber ID Number	
Subscribers Name (Policy Holder)	Social Security Number	Date of Birth	Sex ☐ Female ☐ Male ☐ Other	Relationship to Patient
Subscribers Employer Name	Subscriber Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired		Subscriber Phone Number	

Print Name	Date	Print Guardian Name	Date
Patient Signature		Guardian / Legal Representative Signature	

PLACE PATIENT LABEL HERE

Today's Date:

Patient Name:

MRN: Date of Birth:

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)

Official Use

☐ Data Entered Into Epic ☐ Insurance Card Scanned ☐ Driver's License/Picture ID Scanned