

Community Health Medical Home

# Patient Registration

DATE \_\_\_\_\_

## PATIENT INFORMATION

Name (Last) \_\_\_\_\_

(First) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social security number \_\_\_\_\_

Marital status \_\_\_\_\_

Maiden name \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

Primary phone \_\_\_\_\_

Secondary phone \_\_\_\_\_

E-mail address \_\_\_\_\_

May we provide personal information in a voice mail?

Yes  No

Current employer \_\_\_\_\_

Position \_\_\_\_\_

## EMERGENCY CONTACT

(if different from legal next of kin)

Name (Last) \_\_\_\_\_

(First) \_\_\_\_\_ (MI) \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

## PARENT/GUARDIAN OR RESPONSIBLE PARTY (IF APPLICABLE)

Name (Last) \_\_\_\_\_

(First) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

Relationship to patient \_\_\_\_\_

(spouse, parent, adult child, sibling, other)

## FOR PATIENTS USING INSURANCE TO PAY FOR SERVICES AT SWEDISH COMMUNITY HEALTH MEDICAL HOME

### Insurance Type:

Private Insurance (Name) \_\_\_\_\_

Medicaid (Plan) \_\_\_\_\_

Medicare (Plan) \_\_\_\_\_

### Insurance Information:

Carrier or Company \_\_\_\_\_

ID # \_\_\_\_\_

Group # \_\_\_\_\_

Subscriber Name (if different from patient)

\_\_\_\_\_

### Subscriber Relationship to Patient:

Parent

Spouse/Domestic Partner

Other \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_

Subscriber Social Security Number \_\_\_\_\_