SWEDISH MEDICAL CENTER

Expected Date of Service: _____

PATIENT PRE-REGISTRATION FORM

First Hill ☐ **Cherry Hill** ☐ **Ballard** ☐ **Issaquah** ☐

Please select type of service: **Diagnostic** ☐ **OB** ☐ **Surgery** ☐ **Clinic** ☐

Primary Care Physician: _____ Phone: _____

Patient Name: _____ Social Security #: _____

Sex: _____ Date of Birth: _____

Marital Status: _____ Religious Preference: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

If retired, date of retirement: _____ Employer: _____

Primary Insurance

Insurance: _____ Plan type (HMO/PPO): _____

Policy #: _____ Group #: _____

Ins. Co. Billing Address: _____

Phone: _____

Policy Holder: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

If policy holder of insurance (in order to bill properly): Social Security #: _____ Date of Birth: _____

If retired, date of retirement: _____ Employer: _____

Contacts

Primary contact: _____ Relationship to patient: _____

Home Phone: _____ Emergency: _____

Secondary contact: _____ Relationship to patient: _____

Home Phone: _____ Emergency: _____

CONTACT YOUR PCP OR INSURANCE COMPANY IF YOU ARE UNSURE ABOUT REFERRAL/AUTHORIZATION REQUIREMENTS

Medicaid/Healthy Options

If eligible for Department of Social & Health Services:

Plan: _____

Plan/Member# _____ Case No: _____

PIC #: _____ *Pic # example: JA 070476 SMITH A*

Secondary Insurance

Insurance: _____ Plan type (HMO/PPO): _____

Policy #: _____ Group #: _____

Ins. Co. Billing Address: _____

Phone: _____

Policy Holder: _____

Medicare

Medicare Number: _____ Part A ☐ Part B ☐

MEDICARE QUESTIONNAIRE - Required for all Medicare Patients

Yes ☐ No ☐ Are you receiving Black Lung Benefits?

Yes ☐ No ☐ Are services to be paid by a Government Program (IE. Research grant)?

Yes ☐ No ☐ Has the Department of Veterans Affairs authorized care at this facility?

Yes ☐ No ☐ Is your illness or Injury due to a work-related accident or condition?

Yes ☐ No ☐ Is your illness or Injury due to a non-work related accident or condition?

Yes ☐ No ☐ Do you receive group medical coverage based on you or your spouse's current employment?
(Note: this does not include retirement benefits that are secondary to Medicare)

Are you entitled to Medicare based on: Yes ☐ No ☐ Age

Yes ☐ No ☐ Disability

Yes ☐ No ☐ End Stage Renal Disease (ESRD)

Have you been admitted to a hospital overnight in the last 60 days? Yes ☐ No ☐

If Yes, provide name of facility and date: _____

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

Work* Auto Other

Claim #: _____

Date of Injury: _____

*Employer: _____

Phone: _____

Briefly describe how injury occurred: _____