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 ☐ Hispanic ☐ Non Hispanic ☐ Other	Race
Home Phone	Work Phone		Cell Phone	Religion
Employer Name	Employment Status ☐ Full time ☐ Part time ☐ Student		Retirement Date (if applicable)	Occupation
Emergency Contact Name	Emergency Contact Number			Relationship
Primary Care Provider Name	Primary Care Provider Phone #		Referred?	Referred By Name/#

Guarantor (Person Responsible for Bill)

Last Name	First Name		Middle Name	Relation to 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 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 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 Information

1. Are you over 65 years of age and is this why you have Medicare Part B benefits? ..... **Yes / No**

2. Are you employed right now? ..... **Yes / No**

3. Is your spouse employed right now? ..... **Yes / No**

4. Are you covered by a health plan from your own or family member's current employment? ..... **Yes / No**

↳ Does the employer have 20 or more employees? ..... Yes / No

5. Are you or your spouse retired? ..... **Yes / No**

↳ Your retirement date: ____/____/____

↳ Spouse's retirement date: ____/____/____

↳ Spouse's name: _____

6. Do you have Medicare because of end stage renal disease (ESRD)? ..... **Yes / No**

↳ Is ESRD the reason you first became eligible for Medicare? ..... Yes / No

↳ Are you within the first 30 months of treatment for ESRD? ..... Yes / No

7. Is the reason you have Medicare due to a disability, other than ESRD? ..... **Yes / No**

↳ Are you covered by a group health plan of an employer with over 100 employees? ..... Yes / No

8. Has the Department of Veterans Affairs (VA) authorized and agreed to pay for the services at this facility today? ..... **Yes / No**

Note: VA benefits are separate from TRICARE medical coverage. A "yes" answer means the VA sent you here today.

9. Were you a coal miner and are you entitled to benefits under the Federal Black Lung Program? ..... **Yes / No**

10. Is this illness or injury due to a work related accident, and will your bill today be sent to a Workers' Compensation Carrier primary to or instead of Medicare ..... **Yes / No**

11. Is this illness or injury the result of a non-work related accident (i.e. motor vehicle accident)? ..... **Yes / No**

↳ Do you have non-fault or liability insurance (i.e. auto insurance) that we should bill instead of Medicare for your services today? ..... Yes / No

12. Are services to be paid by a government research program? If yes, please provide billing instructions to the front desk ..... **Yes / No**

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: _____

_____

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