SWEDISH MEDICAL GROUP

REGISTRATION FORM

PATIENT LABEL HERE

Patient Information

Last Name	First Name	Middle Name	Alias or Maiden Name

Date of Birth	Sex	Marital Status	Race	Religious pref	Social Security Number	Employer Name

Street Address	City	State	Zip

Home Phone	Work Phone ☐ Patient ☐ Mother ☐ Father	Cell Phone ☐ Patient ☐ Mother ☐ Father
Email Address	Emergency Contact Name & Relationship	Emergency Contact Phone #
	Emergency Contact Name & Relationship	Emergency Contact Phone #

Guarantor

Last Name	First Name	Middle Name	Alias or Maiden Name

Date of Birth	Sex	Marital Status		Social Security Number	Relationship to the patient

Street Address (if different from above)	City	State	Zip

Home Phone	Work Phone ☐ Mother ☐ Father ☐ Guardian	Cell Phone ☐ Mother ☐ Father ☐ Guardian
Email Address	Employer Name	Occupation

Insurance Information

Primary Insurance

Insurance Company Name	Group Number	Subscriber ID Number	Copay

Subscribers Name	Social Security Number	Date of Birth	Relationship to the patient

Subscribers Employer Name	Subscribers Home Phone	Subscribers Work Phone

Secondary Insurance

Insurance Company Name	Group Number	Subscriber ID Number	Copay

Subscribers Name	Social Security Number	Date of Birth	Relationship to the patient

Subscribers Employer Name	Subscribers Home Phone	Subscribers 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
❑ Drivers license/picture ID scanned

Parent or Guardian: _____