SWEDISH
MEDICAL GROUP

Patient Registration

Please print clearly and answer all questions. **Today's date:** _____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (Middle) _____

If minor child, parent's name: _____

Home address: _____
STREET CITY STATE ZIP

Billing address: _____
STREET CITY STATE ZIP

Home phone: _____ Cell phone: _____

Work phone: _____ Email address: _____

Social Security Number: _____

Birthdate: _____ Age: _____ ☐ Male ☐ Female Race (required): _____

Patient employment: ☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Employer: _____ Phone: _____

Marital status *(check one)* ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's name: _____ Spouse's birthdate: _____
(REQUIRED FOR INSURANCE BILLING)

Spouse's or (if minor) parent's employer: _____

Spouse's or parent's business phone: _____

Person to contact in case of emergency: Name: _____

Phone: _____ Relationship: _____

MEDICAL INFORMATION

Condition being seen for today: _____

Referred by (name and address): _____

_____

☐ Doctor ☐ Self ☐ Friend ☐ Other: _____

Primary care physician: (name and address): _____

_____

Patient signature: _____

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 888-313-9127 (Swedish Edmonds 888-311-9178) (TTY:711)