SWEDISH MEDICAL GROUP
REGISTRATION FORM

PATIENT LABEL HERE

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	Race
Home Phone	Work Phone		Cell Phone	Religion
Employer Name	Employment Status		Retirement Date (if applicable)	Occupation
Emergency Contact Name	Emergency Contact Number		Relationship	
Primary Care Provider Name	Primary Care Provider #	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
Subscribers Name	Social Security Number	Date of Birth	Sex	Relationship to Patient
Subscribers Employer Name	Subscriber Employment Status	Home Phone		Work Phone

Secondary Insurance

Insurance Company Name	Group Number		Subscriber ID Number	Copay
Subscribers Name	Social Security Number	Date of Birth	Sex	Relationship to Patient
Subscribers 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
❑ Drivers license/picture ID scanned

Parent or Guardian: _____

SWEDISH
MEDICAL GROUP

Patient Notification for Payer Payment Policies for Certain In-Office Procedures

Patient Name: _____

Please be aware that certain procedures performed in our office are not included in the standard office visit. These procedures will be billed separately and in addition to office visit charges. We have become aware that some insurance carriers are classifying these procedures as "Surgery" and applying the charges to a higher deductible amount. The result may be insurance payment for an office visit but not a procedure. In such cases, payment for the procedure will be due from the patient. Be assured that we are following accepted billing and coding guidelines and that all procedures are performed in the best interest of patient care.

Examples of in-office procedures include:

Flexible laryngoscopy: This procedure involves passing a long thin flexible fiberoptic scope through the nasal cavity and into the throat. The fiber optic scope enables the physician to visualize areas of the throat not readily seen using the laryngeal mirrors.

Nasal endoscopy: This procedure uses the flexible or rigid scope attached to a light source to view areas of the nasal cavities that cannot be viewed by the physician using the standard nasal speculum and head mirror.

Nasal endoscopy with debridement or biopsy: This is the same procedure as above with removal of crusting or tissue.

Please speak with our nurse or clinical assistants if you have any questions.

_____ _____

Patient Signature Date

Swedish Otolaryngology Health History Form

PATIENT LABEL

Patient Name: _____

Birthdate: _____ Height: _____ Weight: _____

Reason for today's visit: _____

Current and prior illnesses or injuries: _____

_____

Issues with bleeding/clotting, hypertension, diabetes mellitus, obstructive sleep apnea, thyroid problems:

_____

Surgeries/Hospitalizations	Year	Complications

Problems with anesthesia? ☐ No ☐ Yes (if yes, please explain) _____

Current Medications (or provide list to copy)	Dose	Number of times/day

Drug Allergies: None Penicillin Aspirin Latex Tape Iodine

Other: _____ Reaction: _____

Social History: Occupation: _____ Marital Status: _____ Children: _____

Tobacco use/type: _____ No. of years: _____ When did you quit? _____

Alcohol use: ☐ No/never ☐ No, but I used to. ☐ Rarely ☐ Occasionally ☐ Daily Drug use/type: _____

Family History:

Relative	Age if alive	Health conditions	Cause of death
Mother			
Father			
Siblings			

PATIENT LABEL

Review of Symptoms

Do you currently have or have you had chronic or recurrent problems with:

	Yes	No
Fever		
Weight loss		
Excessive fatigue		
Night sweats		
Eyes		
Glasses - Date of last exam:		
Eye infections		
Eye injuries		
Glaucoma		
Cataracts		
Ear, nose, throat, and mouth		
Hearing aids (*circle*) L R Both		
Date of last hearing exam:		
Hearing loss		
Ear pain		
Ear infections		
Ringing in ears/tinnitus (*circle*) L R		
Balance disturbance (spinning/vertigo)		
Nosebleeds		
Nasal congestion		
Nasal drainage (amount/color):		
Inability to smell		
Sinus problems		
Sinus headaches		
Sore throat		
Mouth sores		
Cardiovascular		
Chest pain/angina		
Date of last EKG:		
High blood pressure		
Irregular pulse		
Heart murmur		
High cholesterol		
Swelling in feet or hands		
Leg pain while walking		
Pacemaker		

	Yes	No
Respiratory		
Asthma		
Chronic cough		
Emphysema		
Shortness of breath		
Bronchitis		
Pneumonia		
Lung cancer		
Bloody sputum		
Date of last chest x-ray:		
Gastrointestinal		
Indigestion or pain with eating		
Nausea		
Vomiting		
Blood in vomit		
Liver disease		
Jaundice		
Abdominal pain		
Change in bowel habits		
Ulcers or gastritis		
Colon cancer		
Genitourinary		
Urinary tract infections		
Painful urination		
Blood in urine		
Difficulty in starting/stopping stream		
Involuntary urination		
Kidney stones		
Prostate cancer (males)		
Endometriosis (females)		
Uterine or cervical cancer (females)		
Integumentary		
Skin disease		
Skin cancer		
Breast pain, tenderness, and/or swelling		
Nipple discharge		
Date/result of last mammogram:		

PATIENT LABEL

	Yes	No
Musculoskeletal		
Broken bones - List:		
Arm or leg weakness		
Back pain		
Arm or leg pain		
Joint swelling		
Arthritis		
Neurological		
Fainting spells or "blacking out"		
Seizures		
Problems with memory		
Disorientation		
Difficulty with speaking		
Inability to concentrate		
Double or blurred vision		
Face weakness		
Coordination in arms/legs		
Reproductive		
Females: Current pregnancy		

	Yes	No
Psychiatric		
Anxiety		
Depression		
Other psychiatric disorders/treatment - List:		
Endocrine		
Diabetes		
Thyroid disease		
Increased appetite		
Excessive thirst or urination		
Hormone problems		
Hematologic/Lymphatic		
Anemia		
Hemophilia		
Bleeding tendencies		
Persistent swollen glands/lymph nodes		
Blood transfusion - When:		
Allergic/Immunologic		
Allergies (*circle*) Food Inhalant/nasal		
Immunologic disorders		
Allergy testing - When:		

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Medicare

Medicare Number: _____ Part A ☐ Part B ☐

MEDICARE QUESTIONNAIRE - Required for all Medicare Patients

MSP General Information

Are your (patient's) Medicare benefits based on age? ..... Yes/No

Are you employed? ..... Yes/No

Is your spouse employed? ..... Yes/No

If yes, are you covered by an employer's health plan? Yes/No.....does the employer have 20 or more employees? Yes/No

Are you or your spouse retired? Neither / Patient / Spouse. *If yes, spouses name* _____

patients retirement date _____ *spouses retirement date:* _____

Are you entitled to Medicare because of end stage renal disease? ..... Yes/No

Are you entitled to Medicare because of disability, other than ESRD? ..... Yes/No

Has the department of veterans affairs (DVA) authorized to pay for care at this facility? ..... Yes/No

Are you entitled to benefits under the Federal Black Lung Program? ..... Yes/No

Is this illness/injury due to a work related accident? ..... Yes/No

Is this illness/injury due to a third party responsible related accident? ..... Yes/No

Are services to be paid for by a government research program? ..... Yes/No

Information supplied by: _____ Relationship to patient _____

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

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: _____