SWEDISH

Patient Enrollment Form

Return this completed form to your primary dental clinic. If you need help, your dental clinic can assist you. Swedish Community Specialty Clinic will contact you when we have received this completed form

Patient Information

First Name	Middle Initial	Last Name

Male / Female	Last 4 Digits of Social Security Number (Optional):	Date of Birth:	Employer Name (if applicable): weekly hours:

Patient/legal Guardian Information

* Patients under the age of 18 will need to be accompanied by LEGAL Guardian

Legal Guardian Name (IF PATIENT IS UNDER 18)	Best phone number to Reach you (day):	Other Phone Number:

Address:	Are you homeless? Yes No

City:	State:	Zip:

Do you speak English? Yes No IF "No," what is your spoken language?	Do you need an interpreter? Yes No IF "Yes," what language?	Race/Ethnicity:

What is your **monthly** household income?	How many people are in your household? (That you are responsible for by marriage, birth or adoption) Are supported by monthly household income _____ People

Insurance Information

o Uninsured o Insurance Name:_____	Apple Health/Provider One Number:_____

Agreement and Signature

I understand that:

If I have Apple Health/Provider One, Medicaid, Medicare or any other insurance, I will show that card.

I will follow the Swedish Community Specialty Clinic plan of care and the advice of our provider(s).

I will fill prescriptions and take medicines as told.

I will supply information to Swedish Community Specialty Clinic staff when I am asked.

Sometimes the care I need is not available through Swedish Community Specialty Clinic, and I will assume responsibility for services I receive outside of the Swedish Community Specialty Clinic.

I will seek coverage for which I am eligible and will inform Swedish Community Specialty Clinic.

If I start to receive Apple Health, Provider One, Medicare or other insurance, I will inform Swedish Community Specialty Clinic.

If I file for disability, a Labor & Industries claim, or enter into a lawsuit or settlement, I may become ineligible for Swedish Community Specialty Clinic services. The treating provider will not be responsible for completing paperwork and related follow-up services to assist in the filing(s).

If I recover settlement/payment for the injury/illness for which I am seeking assistance from the treating provider and/or Swedish Community Specialty Clinic treatment have the right to recoup payment for the services/treatment.

If my income or family size changes, I may become eligible for state or other insurance for which I am not currently eligible.

I promise that:

I am a permanent resident of King County.

I will keep every scheduled appointment. If I miss two appointments without canceling at least a day in advance, I will be terminated.

I will treat health care providers with respect and give them my full attention during appointments. If I do not, I will be terminated.

The information I have given is accurate and complete to the best of my knowledge.

SIGNATURE of Patient OR Legal Guardian	Relationship	DATE

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