SWEDISH

PATIENT PRE-REGISTRATION FORM - SOMALI First Hill ☐ Cherry Hill ☐ Ballard ☐ Issaquah ☐
WARQADA BUUKANKA DIIWAAAN GALINTA KAHOR Edmonds ☐

Expected Date of Service:_____ **please select type of service: Diagnostic OB ☐ Surgery ☐ Clinic ☐**
Waqtiga la filayo adeega_____ **Fadlan dooro noca adeega Cudur Barid ☐ Dhakhtarka Dumarka ☐ Qallitan ☐ Xaarunta ☐**

Patient Information/Maclumadka Bukanka

LAST NAME/ **Magaca Dhanbe**	FIRST NAME/**Magaca Hore**		MIDDLE NAME/ **Magaca Dheexad**	
ALIAS OR MAIDEN NAME/ **Magacaga inta anan lagu guursan**	SEX/ **Jinsiga**	BIRTHDAY DATE/ **Taarikhada Dhalaashada**	SOCIAL SECURITY#/ **Social Securitiga**	MARITAL STATUS/ **Xalada Guurka**
STREET ADDRESS/ **CINWAANKA**	CITY/ **MAGALADA**		STATE/ **GOBOLKA**	ZIP CODE/ **ZIIB COODEKA**
LANGUAGE/ **LUUQAADA**	NEED INTERPRETER/ **TARGUUMAD MIYAD UU BAAHANTAHAYE?**		ETHNICITY/ **ASALKA**	RACE/ **ASALKA**
HOME PHONE/ **TALEFANKA GUURIGA**	WORK PHONE/ **TALEFANKA SHAAQADA**		CELL PHONE/ **TALEFANKA QACANTA**	RELIGION/ **DIINTA**
EMPLOYER NAME/ **MAGACA MEESHAD KA SHAAQEESID**	EMPLOYMENT STATUS/ **XALADA SHAAQADA**		RETIREMENT DATE (IF APPLICABLE)/ **TAARIKHDA HAWLGAB (HAADEY KU HABBOON TAHAY)**	OCCUPATION/ **SHAQO**
PRIMARY CARE PROVIDER NAME/ **MAGACA DHAKHTARKAGA**	PROVIDER CARE PHONE#/ **TALEEPHANKA DHAKHTARKAGA**		REFERRED?/ **YA KU SOO DHIIRAY?**	REFERRING PROVIDER NAME/#/ **MAGACA DHAKHTARKA KU SOO DHIIRAY**

Guarantor (Person Responsible for Bill)/KAFAALO QAADAHA (QOOFKA KA MASUULAH QAANSHEEGADA) ☐Self/ **QOOFKA**

LAST NAME/ **Magaca Dhanbe**	FIRST NAME/ **Magaca Hore**	MIDDLE NAME/ **Magaca Dheexad**		RELATIONSHIP TO PATIENT/ **XAARIRKA BUKANKA**
ALIAS OR MAIDEN NAME/ **Magacaga inta anan lagu guursan**	SEX/ **Jinsiga**	BIRTHDAY DATE/ **Taarikhada Dhalaashada**	SOCIAL SECURITY#/ **Social Securitiga**	MARITAL STATUS/ **Xalada Guurka**
STREET ADDRESS/ **CINWAANKA**	CITY/ **MAGALADA**		STATE/ **GOBOLKA**	ZIP CODE/ **ZIIB COODEKA**
EMPLOYER NAME/ **MAGACA MEESHAD KA SHAAQEESID**	OCCUPATION/ **SHAQO**		EMPLOYMENT STATUS/ **XALADA SHAAQADA**	

Insurance Information/MACLUMADKA CAYMISKA
Primary Insurance/CAYMISKAUGU HOREYA

INSURANCE COMPANY NAME/ **MAGACA SHARIKADA CAYMISKA**	GROUP NUMBER/ **NAMBARKA**	SUBSCRIBER ID NUMBER/ **ID NAMBARKA QOOFKA RUKMADAYE**	INS. ADDRESS **/ CINWANKA CAYMISKA**	
SUBSCRIBER'S NAME/ **MAGACA RUKMADEYAHA**	SOCIAL SECURITY #/ **NAMBARKA SOCIAL SECURITYIGA#**	BIRTH DATE/ **TAARIKHDA DHALASHADA**	SEX/ **Jinsiga**	RELATIONSHIP TO PATIENT/ **XAARIRKA BUKANKA**
SUBSCRIBER'S EMPLOYER NAME/ **MAGACA SHAQADA RUKMADEYAHA**	SUBSCRIBER EMPLOYMENT STATUS/ **XALADA SHAQADA RUMMADEYAHA**	HOME PHONE/ **TALEFANKA GUURIGA**	WORK PHONE/ **TALEFANKA SHAAQADA**	

Secondary Contact's XARIIRIYAHA LABAAD

INSURANCE COMPANY NAME/ **MAGACA SHARIKADA CAYMISKA**	GROUP NUMBER/ **NAMBARKA**	SUBSCRIBER ID NUMBER/ **ID NAMBARKA QOOFKA RUKMADAYE**	INS. ADDRESS **/ / CINWANKA CAYMISKA**	
SUBSCRIBER'S NAME/ **MAGACA RUKMADEYAHA**	SOCIAL SECURITY #/ **NAMBARKA SOCIAL SECURITYIGA #**	BIRTH DATE/ **TAARIKHDA DHALASHADA**	SEX/ **Jinsiga**	RELATIONSHIP TO PATIENT/ **XAARIRKA BUKANKA**
SUBSCRIBER'S EMPLOYER NAME/ **MAGACA SHAQADA RUKMADEYAHA**	SUBSCRIBER EMPLOYMENT STATUS/ **XALADA SHAQADA RUMMADEYAHA**	HOME PHONE/ **TALEFANKA GUURIGA**	WORK PHONE/ **TALEFANKA SHAAQADA**	

Emergency Contact's QOFKA LA LA SO XARIIRO XALADA GARGARKA

PRIMARY CONTACT/ **MAGACA IGU HOREYA**	RELATIONSHIP TO PATIENT/ **XAARIRKA BUKANKA**
HOME PHONE/ **TALEFANKA GUURIGA**	EMERGENCY/ **NAMBARKA TELEFANKA QOFKA GARGARKA**
SECONDARY CONTACT/ **MAGACA LABAAD**	RELATIONSHIP TO PATIENT/ **XAARIRKA BUKANKA**
HOME PHONE/ **ĐIỆN THOẠI NHÀ #**	EMERGENCY/ **NAMBARKA TELEFANKA QOFKA GARGARKA**
CONTACT YOUR PCP OR INSURANCE COMPANY IF YOU ARE UNSURE ABOUT REFERRAL/AUTHORIZATION REQUIREMENTS *LA XARIIR DHAKHTARKAGA AMA SHARIKADA CAYMISKA HADADAN KA HUUBIN GUDBINTA/WAXABAHA OGALAANSOOCALBAAHANYAHEY*	

Medicare/ CAYMISKA Medicare

Medicare Number:_____ Part A ☐ Part B ☐

NAMBARKA Medicare:_____ **QAYBTA A ☐ QAYBTA B ☐**

MEDICARE QUESTIONNAIRE – Required for all Medicare Patients
WARBIXINTA/ SUALAHA MEDICARE – WAXA LOGA BAHAANYAHEY BUKANDA MEDICARE O DHAN

Yes ☐ No ☐ Are your receiving Black Lung Benefits?
HA ☐ MAYA ☐ Miyad qaadata manaaficda Black Lung?

Yes ☐ No ☐ Are services to be paid by a Government Program (I.E. Research grant)?
Ha ☐ Maya ☐ Adeegyadan mawax bixinaya boorgaarm xukuumiah (I.EBaaris lacageed)?

Yes ☐ No ☐ Has the Department of Veterans Affairs authorized care at this facility?
Ha ☐ Maya ☐ Qaybta Ciidamada u sochalgamey wadanka miyeyu ogaalatey xanaandbuuxda dhismaha ama xaruunta?

Yes ☐ No ☐ Is your illness or injury due to a work-related accident or condition?
Ha ☐ Maya ☐ Cuduurkaga ama dhawacadana xalaad ama shiil shaaqo u geesataye miya?

Yes ☐ No ☐ Is your illness or injury due to a non-work related accident or condition?
Ha ☐ Maya ☐ Cuduurkaga ama dhawacada ma xalaad ama shiil shaaqo u geesatayesan miya?

Yes ☐ No ☐ Do you receive group medical coverage based on you or your spouse's current employment? (Note: this does not include retirement benefits that are secondary to Medicare)
Ha ☐ Maya ☐ Miyad qadata caymis jamci ah shaqada ama xaaskaga /ninkaga shaqaadoda ah (Ogoow: tani kuma jiirto mu-afacaadka haw-l gabka oo ku labaadka ah caymiska Medicare)

Are you entitled to Medicare based on: Yes ☐ No ☐ Age
Miyad ku xaqsantahe Medicare Ha ☐ Maya ☐ Da'
Yes ☐ No ☐ Disability
Ha ☐ Maya ☐ Cuuryanimo
Yes ☐ No ☐ End Stage Renal Disease (ESRD)
Ha ☐ Maya ☐ Heerka ugu dhanbeya cudurada Kalyaha (E*SRD*)

Have you been admitted to a hospital overnight in the last 60 days? Yes ☐ No ☐
60anki malmod oo igu dhanbeye ma jiifsataye isbital? Ha ☐ Maya ☐
If Yes, provide name of facility and date:_____
Hadey ha tahaye sheeg isbitalka iyo tarikhda_____

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.
Warqadan waxa lagu talagale baritanka ka hor uun bees. Hadad su'aalah kore ha ku jawaabtey ama aad munaafacadka Medicare qadatid cuuryanimo ama ESRD darteed maclumad kale ba lagaga baahanyayr sida aan u soocdsino diiwaan galintada.

Accident/Injury Claim● Shiil/kaalemka Dhawaca

Work* **/Shaqo*** Auto/ **Gaari** Other/ **Wax kale**
Claim #/ **Kaalem nambarka:**_____
Date of Injury /**Tarikhda dhawaca**_____
* Employer**/* Shaqadada**_____
Phone/**Talefanka**_____
Briefly describe how injury occurred/ **Si kooban uu sharax sida uu dhawaca uu dhacay**_____
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