SWEDISH
MEDICAL GROUP

PATIENT LABEL HERE

REGISTRATION FORM

Patient Information

Last Name				First Name		MI	Alias or Maiden Name	
Date of Birth	Sex	Marital Status	Race	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 #		

Responsible Party Information

Last Name				First Name		MI	Alias or Maiden Name	
Date of Birth	Sex	Marital Status	Race	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
Subscriber's Name	Social Security Number	Date of Birth	Relationship to the patient	
Subscriber's Employer Name	Subscriber's Home Phone		Subscriber's Work Phone	

Secondary Insurance

Insurance Company Name	Group Number	Subscriber ID Number		Copay
Subscriber's Name	Social Security Number	Date of Birth	Relationship to the patient	
Subscriber's Employer Name	Subscriber's Home Phone		Subscriber's 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: ______________________________

Parent or Guardian: ______________________________

☐ Data entered into Misys
☐ Insurance card scanned
☐ Driver's license/picture ID scanned