SWEDISH

PATIENT REGISTRATION FORM

DIABETES EDUCATION CENTER

Are you a new Patient to this Clinic? ☐ Yes ☐ No

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Patient Name _____ Social Security #__ __ __/__ __/__ __ __ __

Sex: ☐ M ☐ F Birthplace _____ Race _____

Date of Birth _____/_____/_____ Religious Preference _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Life Partner

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

☐ Full time ☐ Part time ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disability ☐ Charity Care

Employer Address _____

City _____ State _____ Zip Code _____

If retired, date of retirement _____/_____/_____

Legal Next of Kin/Spouse/Parent/Child _____ Relationship _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Employer _____ Occupation _____

☐ Full time ☐ Part time ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disability ☐ Charity Care

If policy holder of insurance: Social Security # __ __ __/__ __/__ __ __ __

Date of Birth _____/_____/_____

If retired, date of retirement _____/_____/_____ Employer _____

Emergency contact person _____ Relationship to patient _____

Home Phone _____ Emergency Phone # _____

CONTACT YOUR PCP OR INSURANCE COMPANY IF YOU ARE UNSURE ABOUT REFERRAL!
AUTHORIZATION REQUIREMENTS AND/OR COVERAGE FOR SERVICES PROVIDED

Primary Insurance	**Secondary Insurance**
Insurance	Insurance
Plan type (HMO/PPO)	Plan type (HMO/PPO)
Policy #	Policy #
Group #	Group #
Policy Holder	Policy Holder
Ins. Co. Billing Address	Ins. Co. Billing Address

Medicaid/Healthy Options/Molina

ID# _____ PIC# _____

Program _____

Medicare
Medicare Number:_____

☐ Hospital (Part A) ☐ Medical (Part B) ☐ Part A and Part B

Medicare Patients - Please see reverse side for additional questions
MEDICARE QUESTIONNAIRE - Required for all Medicare Patients

☐ Yes ☐ No – Are you receiving Black Lung Benefits?
☐ Yes ☐ No – Are services to be paid by a Government Program (i.e. Research grant)?
☐ Yes ☐ No – Has the Department of Veterans Affairs authorized care at this facility?
☐ Yes ☐ No – Is your illness or injury due to a work related accident or condition?
☐ Yes ☐ No – Is your illness or injury due to a non-work related accident or condition?
☐ Yes ☐ No – Do you receive group medical coverage based on you or your spouse's current employment?
(Notice: this does not include retirement benefits that are secondary to Medicare)
☐ Yes ☐ No – Is the patient employed?
☐ Yes ☐ No – Is the patient retired?
Patient's retirement date:_____/_____/_____
Are you entitled to Medicare based on:
☐ Yes ☐ No – Age 65 or older
☐ Yes ☐ No – Disability
☐ Yes ☐ No – End Stage Renal Disease (ESRD)

Name of spouse_____
☐ Yes ☐ No – Is the spouse retired
Spouse's retirement date:_____/_____/_____
Is spouse entitled to Medicare based on:
☐ Yes ☐ No – Age 65 or older
☐ Yes ☐ No – Disability
☐ Yes ☐ No – End Stage Renal Disease (ESRD)

Have you been admitted to a hospital overnight in the last 60 days? ☐ Yes ☐ No
If Yes, provide name of facility and date_____

If you have answered "yes" to any of the above questions or are receiving Medicare benefits due to Disability, Black Lung or ESRD more information will be required to process your registration.

Responsibility for Payment & Release of Medical Information (Required)

I consent to medical treatment and consent to the plan of care proposed to me by the service practitioner to whom I have been referred. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse, medical care. I acknowledge that the Medical Center is a teaching hospital and that the teachers, trainees, residents and students may observe or participate in the care provided. I authorize my insurance to pay all benefits to Swedish health Services. I accept all financial responsibilities (charges) not covered by insurance payable within 30 days of invoice. I authorize release of medical records to my insurance company as needed to process this claim.

Signed_____ **Date**_____