SWEDISH

PATIENT PRE-REGISTRATION FORM

First Hill ☐ Cherry Hill ☐ Ballard ☐ Issaquah ☐ Edmonds ☐

Expected Date of Service: _____ Please select type of service: Diagnostic ☐ OB ☐ Surgery ☐ Clinic ☐

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
PRIMARY CARE PROVIDER NAME	PRIMARY CARE PROVIDER #	REFERRED?	REFERRED BY NAME/#	

Guarantor (Person Responsible for Bill) ☐ Self

LAST NAME	FIRST NAME	MIDDLE NAME		RELATIONSHIP TO PATIENT
ALIAS OR MAIDEN NAME	SEX / BIRTH DATE	SOCIAL SECURITY #		MARITAL STATUS
STREET ADDRESS	CITY	STATE		ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE		
EMPLOYER NAME	OCCUPATION	EMPLOYMENT STATUS		

Insurance Information

Primary Insurance

INSURANCE COMPANY NAME	GROUP NUMBER	SUBSCRIBER ID NUMBER	INS. ADDRESS	
SUBSCRIBER'S NAME	SOCIAL SECURITY #	BIRTH DATE	SEX	RELATIONSHIP TO PATIENT
SUBSCRIBER'S EMPLOYER NAME	SUBSCRIBER EMPLOYMENT STATUS	HOME PHONE		WORK PHONE

Secondary Insurance

INSURANCE COMPANY NAME	GROUP NUMBER	SUBSCRIBER ID NUMBER	INS. ADDRESS	
SUBSCRIBER'S NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	SEX	RELATIONSHIP TO PATIENT
SUBSCRIBER'S EMPLOYER NAME	SUBSCRIBER EMPLOYMENT STATUS	HOME PHONE		WORK PHONE

Emergency Contacts

PRIMARY CONTACT		RELATIONSHIP TO PATIENT
HOME PHONE	EMERGENCY	
SECONDARY CONTACT		RELATIONSHIP TO PATIENT
HOME PHONE	EMERGENCY	

CONTACT YOUR PCP OR INSURANCE COMPANY IF YOU ARE UNSURE ABOUT REFERRAL/AUTHORIZATION REQUIREMENTS

Medicare

Medicare Number: _____ Part A ☐ Part B ☐

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 (IE. 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? (Note: this does not include retirement benefits that are secondary to Medicare)

Are you entitled to Medicare based on: Yes ☐ No ☐ Age

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: _____

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

Work* Auto Other

Claim #: _____

Date of Injury: _____

*Employer: _____

Phone: _____

Briefly describe how injury occurred: _____