SWEDISH

ADULT REGISTRATION FORM

PATIENT INFORMATION

Last Name (Legal)	First Name, Middle Name (Legal)		Preferred Name	
Previous Name(s)	Social Security Number		Sex ☐ Female ☐ Male ☐ Other	Date of Birth
Gender Identity ☐ Female ☐ Transgender Female / Male to Female ☐ Other / Non-Binary ☐ Male ☐ Transgender Male / Female to Male ☐ Prefer Not to Disclose	Patient Preferred Pronouns ☐ She / Her ☐ He / Him ☐ They / Them	Primary Care Provider Name	Primary Care Provider Number	
Address		City	State	Zip Code
Home Phone	Work Phone		Mobile Phone	
Religion / Marital Status	Ethnicity ☐ Hispanic or Latino ☐ Decline to Answer ☐ Non-Hispanic or Latino	Race ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Decline to Answer		
Preferred Language (to discuss healthcare)	Would you like to use an interpreter? ☐ Yes ☐ No		Communication Assistance ☐ Hearing ☐ Speech ☐ Vision ☐ Other	
Employer Name	Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired		Occupation	
Emergency Contact Name	Emergency Contact Number		Emergency Contact Relationship to Patient	

RESPONSIBLE PARTY (Legal Guardian / Healthcare Durable Power of Attorney)

Please provide guardianship court order or healthcare durable power of attorney document
(*Healthcare Durable Power of Attorney should only be contacted if the patient is/becomes unable to make his/her own decisions*)

Last Name	First Name	Middle Name	
Home Phone	Social Security Number	Sex ☐ Female ☐ Male ☐ Other	Date of Birth
Address	City	State	Zip Code

PRIMARY INSURANCE

Insurance Company Name	Group Number		Subscriber ID Number	
Subscribers Name (Policy Holder)	Social Security Number	Date of Birth	Sex ☐ Female ☐ Male ☐ Other	Relationship to Patient
Subscribers Employer Name	Subscriber Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired		Subscriber Phone Number	

SECONDARY INSURANCE

Insurance Company Name	Group Number		Subscriber ID Number	
Subscribers Name (Policy Holder)	Social Security Number	Date of Birth	Sex ☐ Female ☐ Male ☐ Other	Relationship to Patient
Subscribers Employer Name	Subscriber Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired		Subscriber Phone Number	

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 Medical Group participates in the training of physicians and other healthcare providers and I will be told when trainees take part of my care. **INITIAL:** _____

NOTIFICATION OF RELEASE FOR PAYMENT:
I understand that 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:

Print Name	Date	Print Name	Date
Patient Signature		Guardian / Legal Representative Signature	

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).
注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)

Official Use
☐ Data Entered Into Epic ☐ Insurance Card Scanned ☐ Driver's License/Picture ID Scanned

PLACE PATIENT LABEL HERE

Today's Date:

Patient Name:

MRN: Date of Birth: