

PATIENT INFORMATION

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

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 <input type="checkbox"/> Data Entered Into Epic <input type="checkbox"/> Insurance Card Scanned <input type="checkbox"/> Driver's License/Picture ID Scanned

PLACE PATIENT LABEL HERE

Today's Date: _____

Patient Name: _____

MRN: _____ Date of Birth: _____