## MErcer island

## endodontics

Maureen L. Swift, DDS MSD

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# PATIENT REGISTRATION

|  |
| --- |
| Today’s Date: |
| PATIENT INFORMATION |
| Patient’s Last Name | First Name | Middle Initial | Date of Birth |
|  |  |
| Is this your legal name? ❑ Yes ❑ No  | Legal or Former Name/s: | ❑ Female ❑ Male |
| Title: ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. | Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Domestic Partnership |
| Street address | City | State  | ZIP Code |
|  |  |  |  |
| Social Security Number | Employer | Occupation |
|  |  |  |
| Cellular Telephone | Home Telephone | Work Telephone |
|  |  |  |
| E-mail Address:  | Preferred Contact Method: ❑Cellular ❑Home ❑Work ❑E-mail |
| How did you hear about Dr. Maureen L. Swift? | Other family members seen here: |
| INSURANCE INFORMATION |
| (Please provide your insurance card to the front desk.) |
| Is this patient covered by insurance? ❑ Yes ❑ No | Primary Insurance Carrier: |
| Patient’s Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other: |
| Subscriber:  | Subscriber Birth Date: | Subscriber’s S.S.N: |
| Insurance I.D.: | Group Number: | Plan Name: |
| Secondary Insurance Coverage? ❑ Yes ❑ No  | Secondary Insurance Carrier: |
| Patient’s Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other: |
| Subscriber: | Subscriber Birth Date: | Subscriber’s S.S.N: |
| Insurance I.D.: | Group Number: | Plan Name: |
| FINANCIAL INFORMATION |
| Individual responsible for payment | Date of birth | Address (if different) | Telephone |
|  |  |  |  |
| Is this person a patient here? ❑ Yes ❑ No | Employer: |
| Occupation | Employer address | Employer Telephone |
|  |  |  |
| IN CASE OF EMERGENCY |
| Individual to contact in case of an emergency | Relationship to patient | Telephone |
|  |  |  |
| My signature indicates that the above information is accurate and true to the best of my knowledge. I understand that I am financially responsible for the costs incurred at this office. I authorize my insurance company to release any information required to process my claims and I authorize claim payments to be paid directly to Mercer Island Endodontics. |
|  |  |
| Signature of patient or personal representative | Date |