## 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 | | |