SUMMIT CLUB AND FOUNDERS CIRCLE PRE-REGISTRATION

SWEDISH MEDICAL CENTER FOUNDATION
747 BROADWAY, SEATTLE, WA 98122-4307 206-386-2738

Please complete all information, typing or printing clearly, and return this form in the envelope provided or fax it to 206-386-2765 before arriving for your next hospital visit.

LAST NAME			FIRST	MIDDLE	PHYSICIAN'S NAME
ADDRESS			CITY/STATE/ZIP		TELEPHONE NUMBER ( )
AGE	SEX	MARITAL STATUS ☐M ☐S ☐WD ☐SEP ☐DIV	RELIGIOUS PREFERENCE	BIRTH DATE	SOCIAL SECURITY NUMBER
OCCUPATION		EMPLOYERS NAME AND ADDRESS			WORK TELEPHONE NUMBER ( )
SPOUSE/NEXT OF KIN			PHONE ( )	RELATIONSHIP	YOUR FATHER'S NAME
ADDRESS			CITY/STATE/ZIP		YOUR MOTHER'S MAIDEN NAME
EMAIL ADDRESS					
IN CASE OF EMERGENCY NOTIFY OTHER THAN NEXT OF KIN				RELATIONSHIP	EMERGENCY TELEPHONE

INSURANCE INFORMATION - PLEASE COMPLETE IN DETAIL.

IMPORTANT: *CALL YOUR INSURANCE COMPANY TO MAKE SURE THAT ALL TERMS & CONDITIONS ARE MET BEFORE YOU ENTER THE HOSPITAL.*

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY NAME	INSURANCE COMPANY NAME
GROUP, LOCAL AND/OR POLICY NUMBER(S)	GROUP, LOCAL AND/OR POLICY NUMBER(S)
PAID THROUGH EMPLOYER: ☐YES ☐NO	PAID THROUGH EMPLOYER: ☐YES ☐NO
IN WHOSE NAME IS THIS INSURANCE	IN WHOSE NAME IS THIS INSURANCE
NAME OF EMPLOYER (OR FORMER, IF RETIRED)	NAME OF EMPLOYER (OR FORMER, IF RETIRED)
INSURANCE CO. BILLING ADDRESS & PHONE NO.	INSURANCE CO. BILLING ADDRESS & PHONE NO.

IF ON **MEDICARE**, GIVE MEDICARE NUMBER AND BRING MEDICARE CARD AT ADMISSION TIME

MEDICARE PATIENTS: IF YOU HAVE BEEN IN A HEALTHCARE FACILITY WITHIN THE LAST 60 DAYS, GIVE NAME OF FACILITY AND DATES

I am a member of the Summit Club or Founders Circle. When I am a patient at Swedish Medical Center, I hereby authorize Swedish Medical Center to provide information about me, including the name of my attending physician, the type of care needed, and the number of days I am expected to be in the hospital, to Swedish Medical Center Foundation Staff or Swedish VIP International Services. The purpose of the disclosure of this information is so the Foundation Staff can request certain benefits of membership on my behalf, such as a private room for hospital stays at Swedish. I understand that I am not required to sign this authorization in order to receive healthcare treatment at Swedish Medical Center.

I understand that the Swedish Medical Center Foundation may contact me regarding contributions and support for Swedish Medical Center and that my information will be kept confidential.

This authorization expires when I am no longer a member of the Summit Club or Founders Circle, but it may be revoked in writing by me at any time, except to the extent that action has been taken in reliance on this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal or state confidentiality law

Signature____ Date____________________________