REGAL PARK
MEDICAL CENTER

8214 Milwaukee Ave • Lubbock TX 79424-0923 • Phone: (806)-795-6421 • Fax: (806)-795-1528

PATIENT REGISTRATION

We are here to help! If you are needing assistance in filling out this section or any portion of the packet please inform the front desk.

PLEASE PRINT AND FILL IN ALL BLANKS. COMPLETE INFORMATION IS REQUIRED.

PERSONAL INFORMATION

Full Legal Name: ______________________ ◯ **Male** ◯ **Female**

Date of Birth: ______________ **Social Security Number:** ______________

Preferred Language: ______________ **Email:** ______________

Street Address: ______________________

City: ______________ **State:** __________ **Zip Code:** __________

Home Number: ______________ **Mobile Number:** ______________

Race: ◯ **White** ◯ **African American** ◯ **Asian** ◯ **Latino/Hispanic** ◯ **Other:** ______________

Marital Status: ◯ **Single** ◯ **Married** ◯ **Widowed** ◯ **Seperated** ◯ **Divorced**

Spouse Name: ______________________ ◯ **Male** ◯ **Female**

Have you been seen here before under a different name? ◯ **No** ◯ **Yes:** ______________

How did you hear about us? ◯ **From a friend** ◯ **From a doctor** ◯ **Driving by** ◯ **Other:** __________

OCCUPATIONAL INFORMATION

Occupational Status: ◯ **Employed** ◯ **Self-Employed** ◯ **Unemployed** ◯ **Retired** ◯ **Disabled** ◯ **Student**

Employer: ______________ **Occupation:** ______________

Street Address: ______________________

City: ______________ **State:** __________ **Zip Code:** __________

Work Number: ______________ **Ext:** ______

EMERGENCY CONTACT INFORMATION

Any emergency contact must be someone other than your spouse.

Full Legal Name: ______________________ ◯ **Male** ◯ **Female**

Date of Birth: ______________ **Relationship to Patient:** ______________

Primary Number: ______________ ◯ **Home** ◯ **Mobile** ◯ **Work** ◯ **Other**

RESPONSIBLE PARTY INFORMATION

Responsible party information is required for patients who are minors or dependents.

Full Legal Name: ______________________ ◯ **Male** ◯ **Female**

Date of Birth: ______________ **Relationship to Patient:** ______________

Primary Number: ______________ ◯ **Home** ◯ **Mobile** ◯ **Work** ◯ **Other**

PATIENT NAME: ____

PREFERRED PHARMACY INFORMATION

Pharmacy Name: ______________________ **Phone Number:** ______________________

Street Address: ____

City: ______________ **State:** ______________ **Zip Code:** ______________

PRIMARY INSURANCE INFORMATION

Insurance Company: ____

Subscriber's Full Legal Name: ____

Subscriber ID #: ______________________ **Date of Birth:** ______________

Phone Number: ______________________ **Relationship to Patient:** ______________________

SECONDARY INSURANCE INFORMATION

Insurance Company: ____

Subscriber's Full Legal Name: ____

Subscriber ID #: ______________________ **Date of Birth:** ______________

Phone Number: ______________________ **Relationship to Patient:** ______________________

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

PLEASE READ AND SIGN BELOW

I hereby authorize the physicians and staff of Regal Park Medical Center to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by my attending physician during any and all visits to Regal Park Medical Center. I understand that I am financially responsible for all charges for services rendered to me. I hereby authorize the physicians and staff of Regal Park Medical Center to release any information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies, third party payors of all categories, doctors, and hospitals. I hereby authorize payment directly to Regal Park Medical Center, the group of benefits or insurance benefits including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for this period of service. I understand that I am financially responsible to Regal Park Medical Center for charges not covered by this authorization. I permit a copy of this authorization to be used in full extent in place of the original.

Patient Signature: ______________________________ **Date:** ______________

or

Responsible Party Signature: ______________________________ **Date:** ______________