REGAL PARK
MEDICAL CENTER

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

PATIENT REGISTRATION

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: _____

Ethnicity ◯ White ◯ African American ◯ Asian ◯ Latino/Hispanic ◯ Other: _____

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ 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: _____

IF A FRIEND OR DOCTOR, please tell us who we can thank for the referral: _____

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

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:** _____