Lubbock Urology Clinic, L.L.P.

PATIENT REGISTRATION FORM

Today's Date: _____

PATIENT INFORMATION

☐ Male ☐ Female Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Last Name: _____ First Name: _____ Middle Int. _____ DOB ____/____/_____

Social Security # _____-_____-_____ Driver's License # _____ State Issued _____

Ethnicity ☐ Hispanic ☐ Not Hispanic ☐ Declined ☐ Unknown Language _____

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Nat. Hawaiian/Pacific Islander ☐ African American ☐ White ☐ Other ☐ Declined ☐ Unknown

Address _____ City _____ State _____ Zip _____

Primary Phone (_____) _____ Secondary Phone (_____) _____ Email _____

Employer _____ Occupation _____ Employer's Phone _____

Emergency Contact _____ Relationship _____Phone (_____) _____

What is your *preferred method* for receiving notices about your follow up care such as lab results? ☐ Email/Portal ☐ Mail ☐ Phone Call

What is your preferred pharmacy: _____ Address: _____

REFERRAL INFORMATION

Primary Care Physician_____ Phone (_____) _____

Referred by: ☐ Doctor ☐ Relative ☐ Friend or ☐ Other

EMERGENCY HEALTH / INFORMATION RELEASE

Lubbock Urology Clinic, LLP and its staff has my permission to notify the following persons of emergency health conditions.

_____

Name Relationship Phone

_____

Name Relationship Phone

INSURANCE INFORMATION

INSURANCE INFORMATION MUST BE COMPLETELY FILLED OUT
(A copy of your insurance card (s) will be taken by the receptionist)

Primary Insurance _____Group #_____ ID #_____ Co-Pay $ _____

Secondary Insurance _____Group # _____ID # _____

Does Your Insurance Require a Referral? ☐ Yes ☐ No Do You Have A Waiting Period? ☐ Yes ☐ No How Long? _____

If the name on the insurance card is not the patient, complete the section below

Insured Name: _____ DOB ___/_____/_____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

☐ Male ☐ Female Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Employer: _____ Insured Social Security # _____-_____-_____Effective Date of Insurance: _____

I accept full responsibility for all charges for service rendered by Lubbock Urology Clinic, LLP. I agree to pay all costs of collections, including reasonable attorney fees. I authorize the release of any medical information necessary for the completion of insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to Lubbock Urology Clinic, LLP of any medical or government benefits due from my insurance and/or government program. I understand my insurance may not pay all my charges and I agree to promptly pay the difference or the entire bill. I have received a copy of the Notice of Privacy Practices statement. I have authorized Lubbock Urology Clinic, LLP to discuss my protected health information with the above named individuals.

_____

Patient's or Authorized Representative's Signature Date

INSURANCE IS FILED AS A COURTESY. CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES ARE EXPECTED AT TIME OF SERVICE-THANK YOU

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