



Lubbock Urology Clinic, L.L.P.

REGISTRATION FORM

Today's date:		PCP:		Social Security Number: -- --		
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security Number:		Home Phone Number:	
City:		State:		ZIP Code:	Cell Phone Number:	
Occupation:		Employer:			Employer Phone Number: ()	
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Physician	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Other family members seen here:						

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date: / /	Address (if different):			Home Phone Number: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer Phone Number: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Name of Primary Insurance				Phone Number:		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home Phone: ()	Work Phone: ()
<p>I understand that I am financially responsible for any balance. I also authorize Lubbock Urology Clinic, LLP or insurance company to release any information required to process my claims.</p> <p>All patients with HMO or Managed Care contract are responsible for obtaining a referral at the time of service. We reserve the right to reschedule appointments if the patient has not obtained the required referral or if co-payment cannot be made.</p> <p>I hereby authorize the payment of my insurance benefits be paid directly to Lubbock Urology Clinic, LLP.</p>				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	