Healthways / Regional Medical Center at Lubec, Inc.

Registration Form

New Update

__/__/__
Today's Date

Patient Name (please print) | - - Social Security Number | S / M / W / D / SEP Marital Status

Previous Name(s) | Male / Female Sex Assigned at Birth | Age | __/__/__ Birthdate

Physical Address | City | State | Zip Code

Mailing Address (if different) | City | State | Zip Code

( ) - Home Phone | ( ) - Cell Phone | ( ) - Work Phone

Employer | ( ) - Work Phone

Email | Do Not Have Email | Choose Not to Disclose

Emergency Contact / Guardian | Relationship to Patient | ( ) - Phone Number

May we give medical information as necessary to your emergency contact? Yes No

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Primary Care Provider (PCP) | Address | ( ) - Phone Number

Primary Medical Insurance | Member ID | Group Number | __/__/__ Effective Date

Secondary Medical Insurance | Member ID | Group Number | __/__/__ Effective Date

Dental Insurance | Member ID | Group Number | __/__/__ Effective Date

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Signature ☐ Patient ☐ Parent ☐ Guardian

Revised 2/26/2020