Healthways / Regional Medical Center at Lubec, Inc.
Patient Registration Form
We care about protecting your privacy.
RMCL does not share personal information or records without your consent.

Circle One: New Patient Established Patient

Today's Date: ____/____/____

Do you have Medical, Dental, or Prescription Insurance (circle one)? Yes No
IF Yes: List ALL current, active medical and dental insurances**:**

_____ Primary Medical Insurance	_____ Member ID	_____ Group Number	____/____/_____ Effective Date
_____ Secondary Medical Insurance	_____ Member ID	_____ Group Number	____/____/_____ Effective Date
_____ Tertiary (Third) Medical Insurance	_____ Member ID	_____ Group Number	____/____/_____ Effective Date
_____ Dental Insurance	_____ Member ID	_____ Group Number	____/____/_____ Effective Date
_____ Prescription Only	_____ Member ID	_____ Group Number	____/____/_____ Effective Date

Please Check One:

_____ I have given copies of the cards listed above to the Receptionist during today's visit.
_____ I refused **or** did not have insurance cards with me at this time. I understand that I may receive a bill for my services if the insurance information I have provided above is not accurate or incomplete.

Patient Information:

Patient's Name:
_____ ____ _____
(First Name) (M.I) (Last Name)

Birthdate: ____/____/_____ **Age:** _____

Social Security #: ____-____-____

Physical Address:
_____
(# and Street)
_____, _____ _____
(City) (State) (Zip)

Mailing Address (if different)**:**
_____
(# and Street)
_____, _____ _____
(City) (State) (Zip)

Home Phone:
(_____) _____ - _____

Cell Phone:
(_____) _____ - _____

Gender at Birth (Circle One)**:**
Male Female

Employer:
_____

Work Phone #:
(_____) _____ - _____

Marital Status (Circle One)**:**
Single Married Widowed
Divorced Separated

Patient's Previous Name (if applicable)**:**
_____ ____ _____
(First Name) (M.I) (Last Name)

Contact Information:
Patient's Email: _____ **or (Circle One)**: I do not have email I choose not to disclose

Emergency Contact/Guardian:
_____ _____ (____) _____ - _____
(Name) **(Relationship to Patient)** **(Phone Number)**
May we discuss medical information with your emergency Contact? (Circle One): **Y N**
May we discuss billing/claim information with your emergency contact? (Circle One)**: Y N**

Primary Care Provider (PCP):
_____ _____ (___) _____-_____
(Name of PCP) **(Address of PCP)** **(Phone of PCP)**

Signature: _____ **( ) Patient ( ) Parent ( ) Guardian**

Revised 11/30/2022