AUBURN PEDIATRIC AND ADULT MEDICINE

PATIENT INFORMATION RECORD

PATIENT INFORMATION **Gender:** ____M____F **SSN:** _____

Name: _____ **DOB:** _____
Last First Middle

Address: _____
Street (Apt) City State Zip

Home phone:(____)_____ **Work:**(____)_____ **Cell:**(____)_____

Email address: _____

Race: (check only one)
- ___American Indian or Alaska Native
- ___Asian
- ___Black or African American
- ___Native Hawaiian or other Pacific Islander
- ___White
- ___Other race or more than one race
- ___Refuse to report

Ethnicity: (check only one)
- ___Hispanic or Latino
- ___Not Hispanic or Latino
- ___Refuse to report

(Our government mandates that we report this information. We do not in any way discriminate.)

GUARANTOR INFORMATION **Gender:** ____M____F **SSN:** _____

(Responsible Party if other than self) **Relationship to patient:** _____

Name: _____ **DOB:** _____
Last First Middle

Address: _____
Street (Apt) City State Zip

Home phone:(____)_____ **Work:**(____)_____ **Cell:**(____)_____

Emergency Contact: _____ **Phone:**(____)_____

PRIMARY INSURANCE **Company:** _____

Subscriber: _____ **Subscriber's DOB:** _____

Gender: ____M____F **Patient's Relationship to Subscriber:** _____

SECONDARY INSURANCE **Company:** _____

Subscriber: _____ **Subscriber's DOB:** _____

Gender: ____M____F **Patient's Relationship to Subscriber:** _____

CONSENT FOR TREATMENT

I authorize Auburn Pediatric and Adult Medicine, L.L.C., and its healthcare providers to provide the treatment(s) deemed necessary for me/my dependent, and to release information related to my visit to any private or government agency providing benefits as needed for the provision of medical care.

INSURANCE ASSIGNMENT

I hereby assign to and authorize payment to Auburn Pediatric and Adult Medicine, L.L.C., and/or its healthcare providers, all benefits payable under the terms of my insurance policy(ies). I have been given the Financial Policy of Auburn Pediatric and Adult Medicine, and understand that I am responsible for paying the amount charged for my care minus the amount paid by my insurance.

SIGNED: _____ **DATE:** _____