Auburn Memorial Medical Services, PC
Patient Registration Form/Consent for Treatment/Assignment of Benefits

Name: ______________________________ Maiden ______________Date of Birth: _________ Age:_____ M/F

Address: ____ Marital Status: ____________________

City: ________________________ State: ______Zip: __________ Employment Status: __________________

Home Phone: ___________________Work Phone: ________________Cell Phone: ______________________

Place of Employment: ____SS#: ____________________________

Parent/Guardian Name (if patient is a minor): ____

Emergency Contact: ____ Phone #: _________________________

Primary Care Physician: ____

Consent for Treatment

I voluntarily give my permission to the health care providers of Auburn Memorial Medical Services, PC and such assistants and other health care providers as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Auburn Memorial Medical Services, PC providers, or until I withdraw my consent in writing.

⇨ SIGNED ____ Date_______________

Assignment of Benefits

I request that payment of authorized Medicare, Medicaid, or any other insurer benefits, be made either to me or my behalf, to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and/or any other insurer and its agents as well as any information needed to determine these benefits payable for related services.

⇨ SIGNED ____ Date________________

HIPAA Privacy Information

May we:

Leave appointment information on:
- ___ On Home Phone
- ___ On Answering Machine
- ___On Cell Phone
- ___On Office Voice Mail
- ___With another Person
- ___ Send through Mail
- ___Send Via E-mail

Leave other medical information on:
- ___ On Home Phone
- ___ On Answering Machine
- ___ On Cell Phone
- ___ On Office Voice Mail
- ___ With another Person
- ___ Send through Mail
- ___ Send Via E-mail

Person(s) authorized to communicate with:

Contact	Relationship	Phone #	Cell Phone#