Auburn Primary Care
1719 Catherine Court ▪ Auburn, AL 36830 ▪ (334) 826 -7220
www.auprimarycare.com

PATIENT INFORMATION

Last Name _____ First Name _____ MI ____

Address _____ City _____ State _____ Zip _____

DOB ____/____/____ Age _____ SSN ____-____-____ Male ☐ Female ☐

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Relationship _____ Phone Number _____

Email Address _____

INSURANCE INFORMATION

① Primary Insurance Name _____ Insured's Name _____

Insured's DOB _____ Relationship to Patient _____

Contract # _____ Group # _____

Effective Date _____ Co-Pay $ _____

② Secondary Insurance _____ Insured's Name _____

Insured's DOB _____ Relationship to Patient _____

Contract # _____ Group # _____

Effective Date _____ Co-Pay $ _____

MEDICAL HISTORY

Last Physician Seen, When, & Why: _____

_____

_____

_____

Current Medications

_____

_____

_____

Allergies

_____

_____

_____

Hospitalizations/Surgeries

Name	Date	Name	Date

Please circle all that apply
PH – Personal History FH – Family History

Anemia	PH	FH	**Heart Attack**	PH	FH
Arthritis	PH	FH	**High Blood Pressure**	PH	FH
Asthma	PH	FH	**Mental Illness**	PH	FH
Cancer	PH	FH	**Stroke**	PH	FH
High Cholesterol	PH	FH	**Migraines**	PH	FH
Diabetes	PH	FH	**Tuberculosis**	PH	FH
Epilepsy/Seizures	PH	FH	**Ulcers**	PH	FH
Glaucoma	PH	FH	**Other** ( )	PH	FH

SOCIAL HISTORY

Single □ **Married** □ **Divorced** □ **Widowed** □ **Living with:** _____

Smoke: **Yes** □ **No** □ **Packs a day:** _____ **How long:** _____

Recently quit: **Yes** □ **No** □ **Want to quit:** **Yes** □ **No** □

Use of illegal drugs (Cocaine, Marijuana, etc.)? **Yes** □ **No** □

Occupation _____ **Religious Pref.** _____

Sexual Pref. **Male** □ **Female** □ **Both** □

OTHER REQUIRED INFORMATION (PLEASE ATTACH)

1. Immunization Records
2. Last three (3) visit notes from previous Primary Care Physician

   NOTE: Please complete the Records Request Form on our website to authorize record transfer from previous Primary Care Physician
3. Copy front and back of all active insurance cards

FOR OFFICE USE ONLY
Recvd: □
Recvd: □
Recvd: □

CONTACT INFORMATION & SUBMISION OF THIS FORM

Address / Mail	Contact / Fax	Hand Deliver / Drop-off
Auburn Primary Care 1719 Catherine Court Auburn, AL 36830	Phone: (334) 826-7220 Fax: (334) 826-7230	Hours of Operation Monday – Thursday: 8am – 5pm Friday – Sunday: Closed

FINALS STEPS

1. Please read the disclosure below and sign where indicated. **NOTE:** There are **three (3)** sections that require a signature.
2. **Allow 2 – 3 weeks** for a clinician to review your complete new patient form, including the notes from your previous Primary Care Physician. Due to the high volume of new patient requests, the review process may take longer.
3. If Auburn Primary Care can meet your specific treatment needs, we will contact you by the phone number(s) provided above to schedule an appointment.

Authorization for Medical and Diagnostic Treatments

(1) I wish to receive treatment at Auburn Primary Care. While I am at Auburn Primary Care, I permit my doctor, Auburn Primary Care and its employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. (2) Auburn Primary Care sometimes serves as a training center for students in a variety of different health care professions. Students will sometimes be allowed to observe procedures which would benefit their educational experience. I do not object to students observing my care, treatment or procedures performed upon me. (3) I

understand that medical equipment/supply company representatives will sometimes be present during a procedure to instruct medical personnel on new equipment or supplies. I do not object to these representatives being present during my care, treatment, or procedures performed upon me. (4) I understand that photographs or films may be taken during the course of my treatment to be made a part of my medical record. I do not object to the taking of these photographs or films.

Release of Medical Information

I, the undersigned as the patient or his/her authorized representative, authorize Auburn Primary Care and any other professionals who provided care, treatment or services to release to my insurance company (ies) or their authorized representative or other appropriate agency (ies) that information which is necessary to validate this claim for payment purposes. This includes my employer if workers' compensation is claimed. Auburn Primary Care is also authorized to release to my physician(s), or the persons authorized to bill for them, such information as necessary for billing purposes, including, without limitation, all records and information pertaining to my medical treatment (including that for drug & alcohol abuse), laboratory & other diagnostic tests results, x-rays, therapy, diagnoses and prognosis. In the event that I am transferred to another healthcare facility, I authorize Auburn Primary Care to make a copy of my medical records for the receiving healthcare facility.

Release of Responsibility for Loss of Valuables

I understand that Auburn Primary Care will not be responsible for valuables, including jewelry, watches, money, etc., not specifically placed in the care of Auburn Primary Care through proper procedures. I also understand that Auburn Primary Care cannot be responsible for personal items such as clothing, glasses, dentures, etc., inadvertently damaged or misplaced during my course of treatment. I accept full responsibility for those valuables or personal items which I choose to keep in my possession.

Patient's Signature: _____ Date: _____ or their

Authorized Representative: Relationship_____
If the patient or their authorized representative is unable to sign, state the reason why here: _____

Assignment of Insurance and Financial Responsibility

I authorize payment of all insurance benefits, basic and major medical, for this period of medical, emergency and/or diagnostic treatments, to be made directly to Auburn Primary Care I understand that I am financially responsible for all charges not covered by my insurance plan, including but not limited to co-pays, deductibles, non-covered charges, professional fees and nurse practitioner professional fees. All efforts for collection of the benefits are for my convenience and do not represent a guarantee for collection or a credit to my account until such time as payment is received by Auburn Primary Care. I also assign the benefits payable for physicians' services to the physicians(s) furnishing the services, or authorize such physicians or physician group to submit a claim to my insurance company(ies). I will be responsible for any collection fees, court cost and/or attorney fees incurred by Auburn Primary Care or any physician participating in my care while collecting on my account(s). Failure to comply by these financial policies and/or recurring instances of collection activity could result in dismissal from the practice. Photocopies of this authorization are as valid as the original. I authorize Auburn Primary Care, its employees and agents to contact me at any/all phone numbers (including cell phone numbers) for the purpose of treatment, insurance and payment. I acknowledge that I may be contacted by telephone at any telephone number associated with my account including wireless telephone numbers, which could result in charges to me. I also may be contacted by text messages or emails, using any email address that is provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices. By my admission to Auburn Primary Care, I acknowledge that I am entering into a credit transaction as defined under The Fair Credit Reporting Act 15 U.S.C.§ 1681and that Auburn Primary Care may, with or without my knowledge, obtain a consumer credit report for all permissible purposes, including, but not limited to, debt collection activities and use the information in connection with a determination of the consumer's eligibility for a license or other benefit granted by a governmental instrumentality required by law to consider an applicant's financial responsibility or status.

Patient's Signature: _____ Date: _____ or their

Authorized Representative: Relationship _____

Acknowledgment of No-Show Policy

Any patient's appointment considered missed or "no-show" will incur a **$25.00** fee per incident. If you, as the patient, are unable to keep the scheduled appointment, please contact Auburn Primary Care at least 2 business days before the scheduled appointment. If the patient fails to notify Auburn Primary Care of their inability to keep the scheduled appointment at least 2 business days in advance, the **$25.00** "no-show" fee will be applied to their account.

Patient's Signature: _____ Date: _____ or their

Authorized Representative: Relationship _____