GEORGE L. AUBLEY, M.D.

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME _____ MIDDLE INITIAL ____ HOME PHONE (____) _____

FIRST NAME _____ WORK PHONE (____) _____ EXT. _____

NAME YOU PREFER TO BE CALLED: _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ ALLERGIES _____

CITY _____ STATE ____ ZIP _____ ☐ Employed ☐ Retired ☐ Student ☐ Other

EMPLOYER _____ OCCUPATION ☐ _____

EMPLOYER ADDRESS _____ SOCIAL SECURITY # _____

CITY _____ STATE ____ ZIP _____ MARITAL STATUS ☐ M ☐ S ☐ D SEX ☐ M ☐ F

NUMBER YOU WISH TO BE CONTACTED WITH RESULTS (____) _____ CAN WE LEAVE A MESSAGE? ☐ Y ☐ N

CAN WE LEAVE RESULTS WITH SPOUSE, GUARDIAN, SIGNIFICANT OTHER? ☐Y ☐N If yes, with whom? _____

SPOUSE / GUARDIAN INFORMATION

NAME _____ RELATIONSHIP TO YOU _____

ADDRESS _____ EMPLOYER _____

CITY _____ STATE ____ ZIP _____ OCCUPATION _____

WORK / DAY PHONE (____) _____ SS # or Driver's Lic. # _____

EMERGENCY CONTACT

NAME _____ RELATIONSHIP TO YOU _____

ADDRESS _____ PHONE (____) _____

CITY _____ STATE ____ ZIP _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other _____

INSURANCE NAME _____ PCP's NAME _____

INSURED / CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID # _____ GROUP # _____ PHONE (____) _____

TREATMENT, PAYMENT AND OPERATIONS CONSENT

I give my consent for George L. Aubley, M.D. to examine and treat me.
I also give my consent to release any necessary medical information for treatment, payment, or healthcare operations.

Patient _____ Date _____

NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of The Notice of Privacy Practices George L. Aubley, M.D. as required by the Privacy Regulations created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient _____ Date _____