

AUM. STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 07-21-17 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Doan R. Majure

Social Security Number: 420-78-2352 Birth Date 12-28-53

Local Phone Number: 334-315-3220 Alternate Number: _____

Local Address: 3 River Rd Lowndesboro Box Number 36752

City: Lowndesboro State: GA Zip Code: 36752

Permanent Address: same

City: _____ State: _____ Zip Code: _____

Marital Status (Please Circle): Single Married Divorced Widowed Other _____

Sex (Please Circle): Male Female

Primary Physician: Hendon City: Montg Phone #: _____

Patient's Employer: Glenwood Inc Work #: 334-262-5944

Parent's or Spouse's Name (Circle which) _____ Phone #: _____

Parent's or Spouse's Employer: _____ Work #: _____

Emergency Contact: Ginger Majure Relationship: sister Phone #: 251-334-666-5550

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☒ Other work

INSURANCE INFORMATION

Do you have health insurance? YES NO

If yes, please give your card to the receptionist in order for a copy to be made for your chart.

Insurance Company _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name _____ Date of Birth ____/____/____

General Consent for Treatment

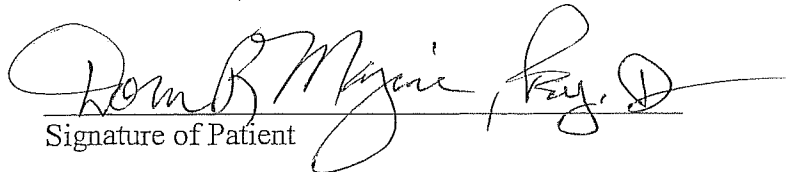
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.


Signature of Patient

07/21/17
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

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