

AUM NURSING CARE CENTER

PATIENT INFORMATION (Print Please)

Date: 10/04/04
Name: James Kyle Taylor
Student ID #: 416 21 0644 Birth Date: 5/3/1969
Local Phone Number: 334 215 2782 Alternate Number: 334 244 3302
Local Address: 7736 Steele Ridge Dr Box Number: _____
City: Montgomery State: AL Zip Code: 36117
Permanent Address: same
City: _____ State: _____ Zip Code: _____
Marital Status: Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other _____
Sex: Male ☒ Female ☐
Primary Physician: Jack Mahurin City: Wetumpka Phone #: _____
Patient's Employer: Aum Work #: 3302
Parent's or Spouse's Name: (indicate which one) Christine Phone #: 394 3200
Parent's or Spouse's Employer: Aifa Work #: ↓
Emergency Contact: Christine Relation: Wife Phone #: 394 3200
How did you hear about our clinic? Friend ☐ Faculty Staff ☐ Orientation ☐ Other: _____

INSURANCE INFORMATION

Do you have health insurance? Yes ☒ No ☐ If yes, please complete the following information.
Name of insured: BC/BS James K. Taylor Relationship to patient: Self
Insurance Company: BC/BS
Policy Number: PPA 416 21 0644 Group Number: 37655
Insurance Company Address: 450 Riverchase Parkway East
City: Bham State: AL Zip Code: 35244

CONSENT FOR TREATMENT

I am requesting care for myself or my above named dependent and give my consent for treatment. I am responsible for all fees for services incurred at the Nursing Care Center.

Signature X: _____

Signature of patient or parent/guardian, if patient is a minor