

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 9-3-14 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Merrill Harvey Ingram

Social Security Number: 416-84-0483 Birth Date: 6-18-57

Local Phone Number: 334-244-0941 Alternate Number: 414-5118

Local Address: 104 Timberlane Rd. Box Number 104

City: Pike Rd. State: AL Zip Code: 36064

Permanent Address: 104 Timberlane Rd.

City: Pike Rd. State: AL Zip Code: 36064

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

Sex (Please Circle): ☒ Male ☐ Female

Primary Physician: Dr. David DeAtto City: Birmingham Phone #: _____

Patient's Employer: Ingram Real Estate Work #: _____

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

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

Emergency Contact: Phyllis S. Ingram Relationship: Spouse Phone #: 334-312-0802
WK 2716678

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

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 _____

Patient Bill of Rights

AUM Nursing Care Center (AUM NCC) exists primarily for the purpose of providing high quality care that meets or exceeds accepted standards for care. AUM NCC believes that each client is worthy of respect and understanding and has certain rights and responsibilities related to the care he/she receives. In accordance with this philosophy, AUM NCC wishes to advise you of the following rights and responsibilities and to assist you in understanding and exercising these rights.

As a client of AUM NCC, you have the right to:

1. Be treated with dignity, courtesy, and respect.
2. Obtain from caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. Know the identity of all caregivers involved in their care, as well as when those involved are students or trainees.
4. Know the immediate and long-term financial implications of treatment choices, insofar as they are known.
5. Make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and AUM NCC policy and to be informed of the medical consequences of the action. In case of refusal, the patient is entitled to other appropriate care and services or to be referred to another health care facility.
6. Receive competent, individualized quality services from AUM NCC regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, or any other category protected by law.
7. Expect confidentiality of all clinical records and access to your records on request. Information will not be released to anyone without your written consent or unless required by law.
8. Have family or guardian exercise these rights on your behalf if you are unable to do so yourself.
9. Voice grievances about care which is or is not provided, recommend policy/service changes, and make complaints without fear of reprisal or unreasonable interruption of care.

I also understand I have a responsibility to:

1. Provide accurate and complete information to AUM NCC regarding medical history and current condition and medications, and to promptly inform AUM NCC of any changes in this information.
2. Agree to accept all caregivers regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified veteran of the Vietnam era, or any other category protected by law.
3. Participate in planning, evaluation and revising my plan of care to the degree that I am able to do so and to take responsibility for my actions and for the impact that those actions have on my health and recovery.
4. Adhere to the plan of care which I have participated in developing.
5. Treat AUM NCC staff with respect, courtesy, and consideration.

I have read and understand the above Patient Bill of Rights and agree to the contents thereof.

Patient Signature: _____ Date: _____

SERVICES CONSENT FORM

NAME: Merrill H. Taylor
DATE OF BIRTH: 6-18-57

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: Merrill H. Taylor
DATE: 8-3-14

SIGNATURE: _____
DATE: _____

SIGNATURE: Merrill H. Taylor
DATE: March 11

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AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 9-3-14 Name Merrill H. Tye

1. What is the reason for your visit today Travel
2. List allergies you have to medicines, foods or iodine: None
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): Insulin 70/30 Victoza
Lamictal Lyrica
4. Have you had any of the following: (circle if this applies to you;):
Heart disease _____
Kidney disease _____
Stomach/Gastrointestinal disease _____
Diabetes/sugar _____
5. Are you immunocompromised? (Is there a problem with your immune system) Yes No
Thymus disorder (Myasthenia gravis, thymoma, thymectomy) _____
Spleen removed _____
Transplant recipient _____
Cirrhosis of the liver _____
Cancer _____
HIV _____
6. How often do you drink beer, wine, wine cooler, or liquor? (Please circle)
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week
7. Where are you going on your trip? Guatemala
8. How long is your trip? Months _____ Days 10
9. When are you leaving on your trip? Sept-20-14

FOR FEMALES ONLY

- A. Date of your last period? _____ Have you had a hysterectomy? YES _____ NO _____
- B. Are you currently pregnant? YES _____ NO _____
What is your due date? _____
- C. Do you plan to become pregnant in the next 3 months? YES _____ NO _____
- D. Are you breastfeeding? YES _____ NO _____