

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 28/05/2019 Are you an AUM student? YES NO Student ID # 500347563.

Name: Patel Karan Jagdishbhai

Social Security Number: _____ Birth Date 31/10/1998.

Local Phone Number: +1 (331) 397-7889 Alternate Number: _____

Local Address: Americas Best Inn Motel Box Number _____

City: Montgomery State: Alabama Zip Code: 36105

Permanent Address: D/202, Shaptha Heights, S.P. ring road, Cgrij

City: Almedabad State: Gujarat Zip Code: 380060.

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

Sex (Please Circle): Male Female

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: _____ Work #: _____

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

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

Emergency Contact: Jun Patel Relationship: Uncle Phone #: +1 (630) 532-7646.

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 _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Patel Arunav Jagdishbhai Date of Birth 31 / 10 / 1998

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

28 / 05 / 2019

Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

AUM Student Health Services
Medical Information Release Form
(HIPPA Release Form)

Name: Patel Gaurav Jagdishhai Date of Birth 31/05/1998

Release of Information

☒ I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

☐ Spouse: _____

☐ Child(ren): _____

☐ Other: _____

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number: (+1)-33130-78809.

If unable to reach me:

☒ You may leave me a detailed message

☐ please leave a message asking me to return your call

☐ other: _____

The best time to reach me is (day or days) All Week between 7:00 am and 12:00 Am times.

Signed: 

Date: 28/05/2019.

AUM Student Health Services PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this 28 day of May 20 19.

Print Patient Name Patel Anurag Jagdishbhai

Signature Anurag

Relationship to Patient _____

AUM Student Health Services

Name Patel Anurav Jagdishbhai Date of Birth 31/10/1998
 PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs ☐ Asthma ☐ Heart Disease (<i>valve, vessel, rheumatic, etc.</i>) ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Pneumonia	Stomach/Bowel ☐ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Stomach/Duodenal Ulcers ☐ Ulcerative Colitis/Crohn's ☐ Other Liver, Stomach, or Bowel Disease	Hematology/Oncology ☐ Anemia ☐ Bleeding Disorders ☐ Blood Clots/Clotting Disorders ☐ Cancer ☐ Radiation Therapy	Anesthesia History ☐ Difficult intubation ☐ Malignant hyperthermia ☐ Post Op Nausea or Vomiting (PONV) ☐ Pseudocholinesterase Deficiency ☐ Spinal headache	STDs ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD
Endocrine ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder	Neurological ☐ Concussions ☐ Convulsions/Seizures ☐ Migraines/Severe Headaches ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Stroke/TIA	Orthopedics ☐ Arthritis ☐ Fractures/Broken Bones	Surgical History ☐ Appendectomy ☐ Adenoidectomy ☐ Ear Tubes ☐ Gallbladder Removal ☐ Knee ACL Repair ☐ Knee Arthroscopy ☐ Organ Transplant	OB/GYN History ☐ Endometriosis ☐ Pregnancies #:
Kidney ☐ Chronic Kidney or Bladder Disease ☐ Kidney Stones	Mental Health ☐ ADHD ☐ Alcohol Abuse ☐ Anorexia (<i>Eating Disorder</i>) ☐ Anxiety Disorder ☐ Bulimia (<i>Eating Disorder</i>) ☐ Depression ☐ Drug Dependency ☐ Other Mental Health Problems	Infectious Diseases ☐ Chickenpox/Varicella ☐ Hepatitis Type: L R ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever	☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☐ Other Prior Surgeries	Exercise History ☐ Lack of exercise ☐ Exercising regularly Moderate Exercising <i>Walking briskly, water aerobics, etc.</i> ☐ Less than 3 times per week ☐ 3 or more times per week Strenuous Exercising <i>Running, swimming laps, etc.</i> ☐ Less than 3 times per week ☐ 3 or more times per week
Ears/Eyes/Nose/Throat ☐ Chronic Sinus Infections ☐ Eye Disorders (<i>other than glasses or contacts</i>) ☐ Hearing Loss ☐ Nasal Allergies/Hayfever		Skin ☐ Eczema ☐ Psoriasis ☐ Hives		

☐ NO Significant Health Problems

List Medications

Allergies

Have you ever had an allergic reaction? ☐ Yes ☐ No

Medication Allergies: _____

Food Allergies: _____

Other Allergies (latex, bee stings, etc.): _____

Other History

☐ Previous Hospitalizations _____

☐ OTHER Health Problems I have
Feel Dizziness after
seeing Blood.

Does YOUR IMMEDIATE FAMILY have any of the following?

☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Alcoholism				
Blood Clots/Clotting Disorders				
Cancer	Breast			
	Colon			
	Melanoma			
	Other Cancers (List Type)			
Diabetes				
Drug Dependency				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Mental Illness				
Stroke				
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				
Parent Deceased				

What is your gender?

- ☐ Female
☒ Male
☐ Transgender
☐ Other

What is your sexual orientation?

- ☒ Heterosexual (Straight)
☐ Gay or Lesbian
☐ Bisexual
☐ Other

Abuse History

As violence is a problem in many families, we ask these questions to ALL patients.

- Verbal Abuse ☐ Yes ☒ No
Physical Abuse ☐ Yes ☒ No
Sexual Abuse ☐ Yes ☒ No

Drug History

Do you take recreational drugs? ☐ Yes ☒ No

How much? _____ How often? _____ What type? Marijuana Cocaine Meth Heroin Spice Other _____

Sexual History

Sexually active? ☐ Yes ☒ No ☐ Not currently

Partners ☐ Male ☐ Female ☐ Both

Birth Control/Protection - Please circle:

Abstinence Birth Control Pills Cervical Cap Condom Diaphragm Implant Injection IUD Patch

Post-menopausal Rhythm Spermicide Sponge Surgical Vaginal Condom Withdrawal Other *see comments* None

Last Menstrual Cycle _____ Last PAP _____ Normal Abnormal (Circle)

Comments:

Tobacco Use History

- ☐ Current every day
☐ Current some days
☐ Former smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker
☐ Never smoker
☐ Passive smoker - never smoked

Please circle:

Type used: Cigarettes Pipe Cigars Hookah E-cigs Chew

Packs/day: 0.25 0.5 1 1.5 2 3

Years: 0.5 1 2 2 4 5 10

Alcohol Use History

- ☐ Current every day
☐ Current some days
☐ Former drinker
☐ Heavy drinker
☐ Social drinker
☐ Never drinks

Please circle:

Type used: Beer Wine Liquor

Drinks/day: 0.25 0.5 1 1.5 2 3 4 5

Years: 0.5 1 2 2 4 5 10