

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 7/30/19 Are you an AUM student? YES ☒ NO ☐ Student ID # _____
Name: BOBZIEN, Merle N
Social Security Number: 556 93 2153 Birth Date 4-26-52
Local Phone Number: 334 593-6574 Alternate Number: 409 289-5074
Local Address: 32 Boulder Court Box Number _____
City: Pike Road State: AL Zip Code: 36064
Permanent Address: Same
City: _____ State: _____ Zip Code: _____
Marital Status (Please Circle): ☒ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____
Sex (Please Circle): ☒ Male ☐ Female
Primary Physician: Hicks City: Montgomery Phone #: 334 613 3680
Patient's Employer: _____ Work #: _____
Parent's or Spouse's Name (Circle which) _____ Phone #: _____
Parent's or Spouse's Employer: _____ Work #: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____
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: _____

Mark R. Begier

Date: _____

7-30-19

Directions for Hep B Shots

Fill out PRVFD Hep B Form return to PRVFD

You must choose to receive or opt not receive the Hept B
vaccination

Or declare that you have already been inoculated.

Fill out the AUM Student Health Center Form excluding the
“Marked-Out” sections if you choose to receive the series of
Hept B Vaccinations.

Call AUM at 244-3281 between the hours of 9:00am to 4:00 pm
Monday thru Friday to schedule your appointment.

Remember to take your filled out AUM Student Health Center
Form with you to Rm 102 at the School of Nursing.

Don't forget to remind them that this gets billed to The
Montgomery County Association of Volunteer Fire Department.

Make sure PRVFD is aware that you followed thru with you last
shot.

SERVICES CONSENT FORM

X NAME: BOBZIEN, Merle R
DATE OF BIRTH: 4-26-52

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.

X SIGNATURE: Merle R Bobzien
DATE: 7-30-19

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AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HISTORY

Date 7-30-19

Name BOBZIEN, Marie R

1. What is the reason for your visit today? Hepatitis B immoc.
2. Is there anything about you and your health that we need to know? no
- *3. List medicine, drugs, or food you are allergic to: None
- *4. List any medicines or drugs you take: Metformin, Lisinopril, Lovastatin
5. Have YOU or anyone in your family had any of the following: (circle)

heart disease

high blood pressure

stroke

diabetes/sugar

blood problem or disease

cancer parents

tuberculosis

birth defects

mental retardation

nerve or mental problems

asthma

died before age 50

other "family" disease

6. Have you ever been in the hospital? yes Why? Clayville plate
7. Have you ever had surgery? yes Why? Clayville plate
8. Have you ever had a serious accident? no accident 5-22-18
9. Have you had serious or recent problems with:

ears or throat

NO

YES

cough

NO

YES

kidneys

NO

YES

gallbladder

NO

YES

allergies

NO

YES

thyroid

NO

YES

weight loss

NO

YES

liver

NO

YES

lung infections

NO

YES

skin problems

NO

YES

ulcers

NO

YES

depression

NO

YES

headaches

NO

YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
- *12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES

If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?

How much smokeless tobacco do you use a day?

- *13. How often do you drink beer, wine, wine coolers, or liquor?
Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
If you drink beer, wine, wine coolers, or liquor, do you have:
(less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
- *15. Have you ever used I.V. drugs? NO YES
16. Have you ever had a blood transfusion? NO YES
17. Do you have any tattoos? NO YES
18. Have you ever been treated for a venereal disease? NO YES
19. Have you had more than one sex partner in the past 5 years? NO YES
20. Have you ever had sex with a member of your own sex? NO YES
21. Have you had or been around anyone with hepatitis? NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? _____ Date of your last period? _____
How often do you have your periods? _____ Are they regular? _____
How many days do they last? _____
Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
Do you check them regularly? YES NO
- *C. How many times have you ever been pregnant? _____ How many children are living? _____
Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
Were any of your children premature? NO YES
How old were you when your first child was born? _____
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES;
diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES