

# AUM STUDENT HEALTH SERVICES

## PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 1/31/20 Are you an AUM Student? ☐ Yes ☒ No SSN# 420-76-8519  
Name: Laurie Dill Preferred: \_\_\_\_\_ Birthdate: 3/1/1958  
Main Phone Number: 286-9205 Email: ldillnd@gmail.com  
Local Mailing Address: 3620 Thomas Ave Box or APT #: \_\_\_\_\_  
City: Montgomery State: AL Zip Code: 36111  
Permanent/Home Address: Same Box or APT #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Marital Status: Single ☐ Married ☐ Divorced ☒ Widowed ☐ Other: \_\_\_\_\_  
Sex: Male ☐ Female ☒ Gender: Male ☐ Female ☒  
Primary Physician: Lois Schulman City: Montgomery Phone #: 334-279-9211  
Patient's Employer: Medical Advocacy Outreach Work Phone #: 280-3349  
Parent's ☐ Spouse's Name: ☒ Larry Monofee Phone #: 334-286-9205  
Parent's or Spouse's Employer: retired Phone #: \_\_\_\_\_  
Emergency Contact: Same Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
How did you hear about the clinic: Friend ☐ Faculty/Staff ☐ Orientation ☐ Other: Physician

## INSURANCE INFORMATION

Do you have health insurance? ☒ YES ☐ NO

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

Insurance Company: Fed BC/BS Name on Card: Laurie E Dill  
Policy or Contract Number: R59459327 Group Number: 105  
Insurance Company's Address: \_\_\_\_\_

# AUM STUDENT HEALTH SERVICES

## CONSENT FOR SERVICES FORM

Patient Name: Laurie Dill Date of Birth: 01/03/1958  
Day Month Year

### General Consent for Treatment

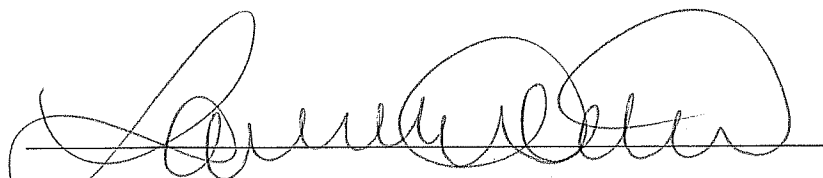
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

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

31 / 01 / 2020  
Day Month Year  
Date of Signature

N/A  
Signature of Legal Representative (if patient is unable to sign)

\_\_\_\_\_  
Relationship to Patient

AUM Student Health Services

Medical Information Release

Form (HIPAA Release Form)

Name: Laurie Dill Date of Birth 03/01/1958

**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: Larry Menefee  
☐ 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: (334)-286-9205 <sup>home</sup>

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) evening between \_\_\_\_\_ and \_\_\_\_\_ times.

Signed: Laurie Dill

Date: 01/31/2020

# 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 involve 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 HIPAA 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 with 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 31 day of Jan 2020.  
(day) (month) (last two digits of the year)

Print Patient's Name: Laurie D. H.

Signature: [Signature]

Relationship to Patient (if you are the patient, write "self"): self

# Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME

Laurie D. H.

DATE OF BIRTH

03/01/1958  
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

|                                                                                                                                                                                                                                                                    | yes                      | no                                  | don't know               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| 1. Are you sick today?                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies to medications, food, a vaccine component, or latex?                                                                                                                                                                                      | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction after receiving a vaccination?                                                                                                                                                                                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?                                                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?                                                                                                                                                                                     | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a seizure or a brain or other nervous system problem?                                                                                                                                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?                                                                                                                   | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?                                                                                                                                                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you received any vaccinations in the past 4 weeks?                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |

yes Tap

FORM COMPLETED BY

Laurie D. H.

DATE

01/31/2020

FORM REVIEWED BY

DATE

Did you bring your immunization record card with you?

yes ☒ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

## AUM Student Health Services - Travel Health History

Date: 01/31/2020 Name: Laurie Dill

1. What is the reason for your visit today? Trip to Africa
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): not SD

4. Have you had any of the following? (Check if this applies to you):

Heart Disease ☐Stomach/Gastrointestinal Disease ☐

Kidney Disease

|                |  |
|----------------|--|
| Diabetes/Sugar |  |
|----------------|--|

5. Are you immunocomprised? (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?

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? South Africa Botswana Zimbabwe

8. How long is your trip? Months 2 Days 15

9. When are you leaving on your trip? May 26, 2020

~~For Females Only~~

- A. Date of your last period? 11/14/2019 Have you had a hysterectomy? Yes ☐ No ☒

- B. Are you currently pregnant? Yes ☐ No ☒ Due date: \_\_\_\_\_

- C. Do you plan to become pregnant in the next 3 months? Yes ☐ No ☒

- D. Are you breastfeeding? Yes ☐ No ☒