

STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 4/22/16 Name Robert L. Branson

1. What is the reason for your visit today Vaccines
2. List allergies you have to medicines, foods or iodine: NKA
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): None

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

Heart disease Yes

Kidney disease Yes

Stomach/Gastrointestinal disease Yes

Diabetes/sugar Clear

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? South Africa, Zambia, Malawi, Mozambique

8. How long is your trip? Months Days 12 * Zimbabwe

9. When are you leaving on your trip? May 12

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

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 4/22/16 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Robert R. Brinson

Social Security Number: 201-88-8407 Birth Date: 7/16/57

Local Phone Number: 334-270-1149 Alternate Number: cell 334-328-0957

Local Address: 9222e Vaughn Rd Box Number _____

City: Price Rd State: Az Zip Code: 36004

Permanent Address: Same

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☒ Female ☐

Primary Physician: DR. TANKERSLEY City: Marietta Phone #: 402-2211

Patient's Employer: Digestive Disease Assoc, PC Work #: 334-271-1205

Parent's or Spouse's Name (Circle which) Parent Phone #: 334-328-2780

Parent's or Spouse's Employer: Digestive Disease Assoc, PC Work #: 334-271-1205

Emergency Contact: Wife or Mrs. Peggy Bennett Relationship: Mother Phone #: 229-944-2081

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 Robert R. Branson MD Date of Birth 7/11/57

General Consent for Treatment

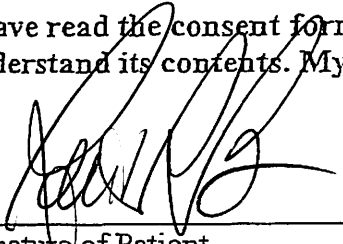
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures and medication administration.

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

4/22/16

Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

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 complete description of 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 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 22 day of April 2016

Print Patient Name

Signature

Relationship to Patient

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

Name: _____ Date of Birth: ____/____/____

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) Christina, Daniel, Philip Brown

☐ 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: 334-328-0987

If unable to reach me:

☒ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) 3PM between (time) 6PM

Signed: [Signature] Date: 4/22/16