

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 1/31/20 Are you an AUM Student? ☐ Yes ☒ No S-Number: L

Name: Larry Menefee Preferred: _____ Birthdate: 5/24/46

Main Phone Number: 334-286-9205 Email: lmenefee3@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: William Smith City: Montgomery Phone #: 263-4444

Patient's Employer: NA Work Phone #: _____

Parent's ☐ Spouse's Name: ☒ Laurie Dill Phone #: 354-1044

Parent's or Spouse's Employer: Medical Aid Outreach Phone #: 354-1044

Emergency Contact: Laurie Dill Relationship: Spouse Phone #: 354-1044

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 front desk in order for a copy to be made for your chart.

Insurance Company: BCBS Name on Card: Laurie Dill

Policy or Contract Number: _____ Group Number: _____

Insurance Company's Address: _____

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Larry Montee Date of Birth: 5 / 24 / 46
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.

Larry Montee
Signature of Patient

31 / 1 / 20
Day Month Year
Date of Signature

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

Relationship to Patient

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME

DATE OF BIRTH

Barry J. Mercier
1/31/20
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?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
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?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
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?	☒	☐	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
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?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY

DATE

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: 1/31/20 Name: Larry Menefee

1. What is the reason for your visit today? shot
2. List allergies you have to medicines, foods or iodine: sulfon drugs & Prednisone
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? (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
8. How long is your trip? Months _____ Days 107 days
9. When are you leaving on your trip? _____

For Females Only

- A. Date of your last period? _____ 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 ☐

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

Name: Larry Menefee Date of Birth 5/24/46

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: (334)-354-1148

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) _____ between _____ and _____ times.

Signed: Larry Menefee

Date: 1/31/20

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 January 2020.
(day) (month) (last two digits of the year)

Print Patient's Name: Kerry Mewster

Signature: [Handwritten Signature]

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