

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: Feb. 10, 2020 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: Connie Daniel Birthdate: 8/17/50

Main Phone Number: 334-318-0433 Email: cjd817@yahoo.com

Local Mailing Address: 8225 Wexford Trace Box or APT #: _____

City: Montgomery State: AL Zip Code: 36117

Permanent/Home Address: same as above Box or APT #: _____

City: _____ State: _____ Zip Code: _____

Marital Status: Single ☐ Married ☐ Divorced ☒ Widowed ☐ Other: _____

Sex: Male ☐ Female ☒ Gender: Male ☐ Female ☐

Primary Physician: Dr. Carmelita De Jesus City: Montgomery Phone #: 244-4322

Patient's Employer: Retired from Montgomery Public Schools (teacher) Work Phone #: _____

Parent's ☐ Spouse's Name: ☐ NA Phone #: _____

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

Emergency Contact: Nancy Hutcheson Relationship: Sister Phone #: (334) 272-6100

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: Humana Peehip Name on Card: Connie N Daniel

Policy or Contract Number: Plan (80840) 9140461101 Group Number: _____

Insurance Company's Address: _____

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Connie Daniel Date of Birth: 8 / 17 / 50
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.

Connie Daniel

Signature of Patient

2 / 10 / 2020
Day Month Year

Date of Signature

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

Relationship to Patient

AUM Student Health Services

Medical Information Release

Form (HIPPA Release Form)

Name: Connie Daniel Date of Birth 8/17/50

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: Nancy Hutcheson (sister)

☐ 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)-318-0433

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: Connie Daniel

Date: 2/10/2020

AUM Student Health Services

PATIENT HIPPAA 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 (HIPPA). 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 HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. 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 10th day of February 2020.
(day) (month) (last two digits of the year)

Print Patient's Name: Connie Daniel

Signature: Connie Daniel

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

AUM Student Health Services - Travel Health History

Date: Feb. 10, 2020 Name: Connie Daniel

1. What is the reason for your visit today? to receive travel immunizations for
2. List allergies you have to medicines, foods or iodine: None Cali, Colombia
(other than my body does not like powerful pain meds like
codine)
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): Losartan Potassium (100 mg day), Paroxetine (10 mg day),
Pravastatin Sodium (20 mg day), Caltrate, Centramin Silver, low dose aspirin,
occasionally alprazolam 25 mg for allergies
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 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 ☐ Skin Cancer ☒ HIV ☐
Non-melanoma
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? Cali, Colombia
8. How long is your trip? Months _____ Days 8 days
9. When are you leaving on your trip? March 14

For Females Only

- A. Date of your last period? NA 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 ☒

