

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 4/2/15 Are you an AUM student? YES ☐ NO ☒ Student ID # Faculty

Name: Pamela S. Tidwell

Social Security Number: 418-04-5991 Birth Date 12-16-61

Local Phone Number: 334 244-6632 Alternate Number: 318-1197

Local Address: 414 Honey Suckle Ct Box Number _____

City: Montgomery State: AL Zip Code: 36109

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Mrylte Goode City: Montgomery Phone #: _____

Patient's Employer: AUM Work #: 244-3363

Parent's or Spouse's Name (Circle which) N/A Phone #: _____

Parent's or Spouse's Employer: N/A Work #: _____

Emergency Contact: Doris Tidwell Relationship: mother Phone #: 256 750-1047

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 BC/BS Name on Card Pamela S. Tidwell

Policy Number PPA838960386 Group Number 37655

Insurance Company Address B'ham, AL

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: _____

Date: _____

SERVICES CONSENT FORM

NAME: Pamela S. Tidwell
DATE OF BIRTH: 12-16-61

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.

SIGNATURE: Pamela S. Tidwell SIGNATURE: _____
DATE: 7/2/15 DATE: _____

SIGNATURE: _____ SIGNATURE: _____
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AUM Student Health Services
Medical Information Release Form
(HIPAA Release Form)

Name: Pamela S. Tidwell Date of Birth: 12/16/61

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 mother - Doris W. Tidwell

☐ 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: 318-1197

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) M-F 9:00-5:00 a.m. between (time) _____

Signed: Pamela S. Tidwell Date: 4/2/15

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 HIPPA 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 2nd day of April 2015.

Print Patient Name Pamela S. Tidwell

Signature Pamela S. Tidwell

Relationship to Patient self

AUM NURSING CARE CENTER
DOLESCENT/ADULT HEALTH HISTORY

Date _____

Name _____

1. What is the reason for your visit today? Stomach ache, Fatigue
2. Is there anything about you and your health that we need to know? I had surgery 2 wks. ago
- *3. List medicine, drugs, or food you are allergic to: Sulfa
- *4. List any medicines or drugs you take: _____

5. Have YOU or anyone in your family had any of the following: (circle)

- | | | | |
|----------------------------|---------------------------------|---------------------------|---------------------------------|
| <u>heart disease</u> | <u>diabetes/sugar</u> | tuberculosis | <u>nerve or mental problems</u> |
| <u>high blood pressure</u> | <u>blood problem or disease</u> | birth defects | asthma |
| <u>stroke</u> | <u>cancer</u> | <u>mental retardation</u> | <u>died before age 50</u> |
| | | | other "family" disease |

6. Have you ever been in the hospital? yes Why? removal of thyroid
7. Have you ever had surgery? yes Why? thyroid removed, ovaries removed
8. Have you ever had a serious accident? no
9. Have you had serious or recent problems with:

- | | | | | | | | |
|-----------------|---------------|---------------|---------------|-------------|---------------|-------------|---------------|
| ears or throat | <u>NO</u> YES | cough | <u>NO</u> YES | kidneys | <u>NO</u> YES | gallbladder | <u>NO</u> YES |
| allergies | <u>NO</u> YES | thyroid | <u>NO</u> YES | weight loss | <u>NO</u> YES | liver | <u>NO</u> YES |
| lung infections | <u>NO</u> YES | skin problems | <u>NO</u> YES | ulcers | <u>NO</u> YES | depression | <u>NO</u> YES |
| | | | | | | headaches | <u>NO</u> 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? none
- *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? yes NO YES
- *15. Have you ever used I.V. drugs? no NO YES
16. Have you ever had a blood transfusion? no NO YES
17. Do you have any tattoos? no NO YES
18. Have you ever been treated for a venereal disease? no NO YES
19. Have you had more than one sex partner in the past 5 years? no NO YES
20. Have you ever had sex with a member of your own sex? no NO YES
21. Have you had or been around anyone with hepatitis? yes NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? no NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? 11 Date of your last period? 12/2013
- How often do you have your periods? not at all 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 NO YES
- Do you check them regularly? no YES NO
- *C. How many times have you ever been pregnant? 0 How many children are living? 0
- Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? no NO YES
- Were any of your children premature? N/A NO YES
- How old were you when your first child was born? N/A
- 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 NO YES
- F. Have you ever had an abnormal PAP smear? no NO YES

Pamela Tidewell

Medications

Vyvanse - 40 mg

Prozac - 40 mg

Wellbutrin - 300 mg

Klonopin - 1 mg - 3x a day

Peplin - 15 mg -

Welchol - 625 mg - 3 @ lunch
3 @ dinner

Livalo - 4 mg

Zetia - 10 mg

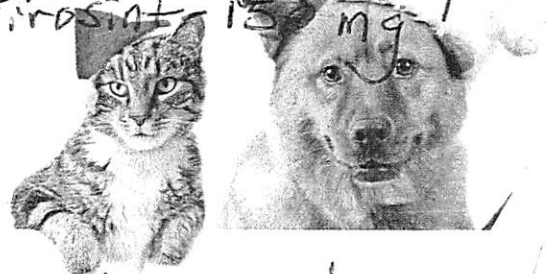
Vitamin D - once a week

Geodon - 160 mg

Trazadone - 100 - mg

Asprin - 81 mg 2x a day

Tirosint - 150 mg



all meds once a day
otherwise noted

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BLUE CROSS
**PREFERRED
CARE**

AUBURN UNIVERSITY

Subscriber Name
PAMELA S TIDWELL
Contract Number
PPA838960386

Group Number	37655
Effective Date	01-01-2004
Rx BIN Number	004915

HEALTH

PAC



Rx