

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

ate: 11/6/2020 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

ame: Josiah Jackson Preferred: _____ Birthdate: 11/21/2017

ain Phone Number: 334-320-2774 Email: _____

ocal Mailing Address: 4965 Felder rd Box or APT #: _____

ity: Hope Hull State: AL Zip Code: 36043

ermanent/Home Address: _____ Box or APT #: _____

ity: Hope Hull State: _____ Zip Code: _____

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

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

Primary Physician: Dent Trumble City: Montgomery Phone #: _____

Patient's Employer: _____ Work Phone #: _____

Parent's ☒ Spouse's Name: ☐ shawson & sonya Jackson Phone #: 334-320-2774

Parent's or Spouse's Employer: AUM Phone #: 334-244-3000

Emergency Contact: Sonya Jackson Relationship: mother Phone #: 334-320-2774

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: Sonya Jackson

Policy or Contract Number: _____ Group Number: _____

Insurance Company's Address: _____

Medical Information Release

Form (HIPAA Release Form)

Name: Josiah Jackson Date of Birth 11/6/2017

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: Sonya Jackson

☐ 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: (____)-____-____

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) anytime between _____ and _____ times.

Signed: _____

Date: 11/6/2020

AUM Warhawk HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Josiah Jackson Date of Birth: 11/21/17
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.

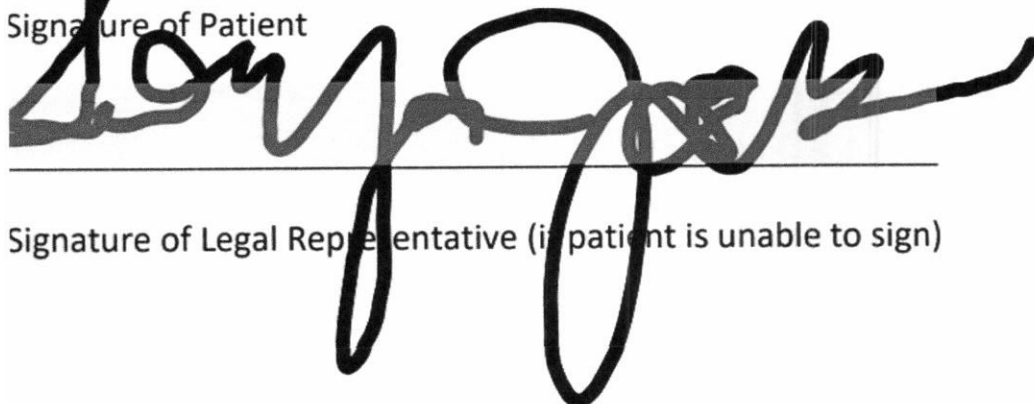
I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.



Signature of Patient

11/6/2020
Day Month Year

Date of Signature



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

mother

Relationship to Patient

AUM Warhawk 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

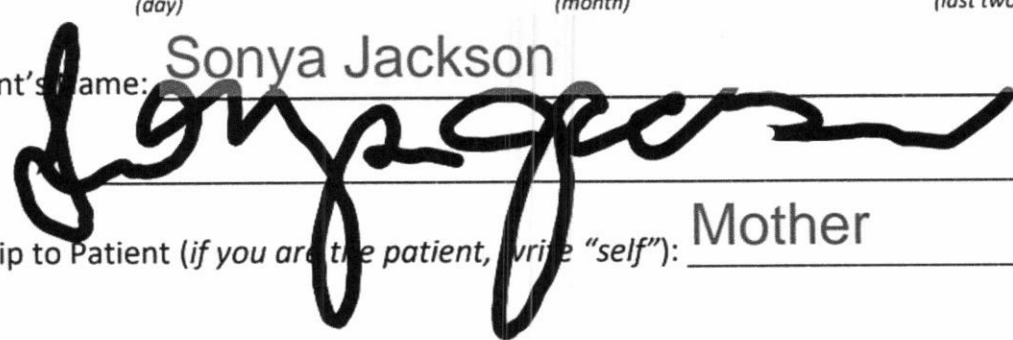
I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPAA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change 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 6 day of November 2020.
(day) (month) (last two digits of the year)

Print Patient's name: Sonya Jackson

Signature: 

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

Date of birth 11/17/2017

Medical:

- ### Anesthesia History:

- ☐
- I've had No significant problems

Surgical:

- | | |
|---|---|
| ☐ Adenoidectomy | ☐ Other surgical |
| ☐ Appendectomy | _____ |
| ☐ Cholecystectomy | _____ |
| ☐ Ear tubes | _____ |
| ☐ Knee ACL tear | _____ |
| ☐ Knee arthroscopy | _____ |
| ☐ Organ transplant | _____ |
| ☐ Ovarian cyst removal | _____ |
| ☐ Splenectomy | _____ |
| ☐ Tonsillectomy | _____ |
| ☐ Weight loss surgery | _____ |

Alcohol abuse	Clotting disorder	Breast cancer	Colon cancer	Melanoma cancer	Other cancer: _____	Diabetes	Drug dependency	Heart disease	High cholesterol	High blood pressure	Learning disabilities	Mental illness	Stroke	Sudden c
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[illegible]

Have you EVER had any of the following?**EXERCISE:**

Do you exercise regularly?

- ☐ Yes
☐ No

I moderately exercise:

- ☐ Less than three times per week
☐ Three or more times per week

I strenuously exercise:

- ☐ Less than three times per week
☐ Three or more times per week

SEXUAL ORIENTATION/GENDER:

What is your sexual orientation?

- ☐ Heterosexual (straight)
☐ Gay or lesbian
☐ Bisexual
☐ Other: mother

What is your gender?

- ☐ Female
☐ Male
☐ Transgender
☐ Other: 6

Preferred Pronoun:

- ☐ He/Him/His
☐ She/Her/Hers
☐ Other: _____

ABUSE HISTORY: *As violence is a problem in many families, we ask these questions to ALL patients.
 Please check all that apply.*

Verbal abuse:

- ☐ Currently experience
☐ Experienced in the past
☐ Never experienced
☐ Choose not to disclose

Physical abuse:

- ☐ Currently experience
☐ Experienced in the past
☐ Never experienced
☐ Choose not to disclose

Sexual abuse:

- ☐ Currently experience
☐ Experienced in the past
☐ Never experienced
☐ Choose not to disclose

ALCOHOL USE:Do you drink? ☐ Yes ☐ No

If yes, how many per week?

Glasses of wine: _____

Cans of beer: _____

Shots of liquor: _____

RECREATIONAL DRUG USE:Do you currently use? Yes ☐ No ☐

Times per week? _____

I use: (Check all that apply)

- | | | | | |
|--|---|--|--|--|
| ☐ Amphetamines | ☐ Amyl nitrate | ☐ Anabolic steroids | ☐ Barbiturates | ☐ Benzodiazepines |
| ☐ "Crack" cocaine | ☐ Cocaine | ☐ Fentanyl | ☐ Flunitrazepam | ☐ GHB |
| ☐ Hashish | ☐ Ketamine | ☐ LSD | ☐ Marijuana | ☐ Ecstasy |
| ☐ Mescaline | ☐ Methamphetamines | ☐ Methaqualone | ☐ Methylphenidate | ☐ Nitrous oxide |
| ☐ Opiates | ☐ Opium | ☐ PCP | ☐ Psilocybin | ☐ Solvent inhalants |

Other: _____

SEXUAL ACTIVITY/BIRTH CONTROL:

Sexually active?

- ☐ Yes
☐ No
☐ Not currently

Partners:

- ☐ Male
☐ Female
☐ Both

Date of last Pap test: _____

Normal: ☐ Yes ☐ No

Date of last menstrual period: _____

Birth control/method of contraception: (Check all that apply)

- | | | | | |
|--|------------------------------------|--|---|---------------------------------------|
| ☐ Abstinence | ☐ Diaphragm | ☐ Patch | ☐ Sponge | ☐ None |
| ☐ Birth control pills | ☐ Implant | ☐ Post-menopausal | ☐ Surgical | ☐ Other: _____ |
| ☐ Cervical cap | ☐ Injection | ☐ Rhythm | ☐ Vaginal condom | _____ |
| ☐ Condom | ☐ IUD | ☐ Spermicide | ☐ Withdrawal | _____ |

TOBACCO USE:☐ Yes ☐ No

Packs a day: (Check one)

☐ 0.25 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 3

Smokeless tobacco?

☐ Yes ☐ No

Start date: _____

Quit date: _____

Ready to quit?

☐ Yes ☐ No

Comments: _____

Have you EVER had any of the following?

MOBILITY:

Do you have a history of falls?

Have you had any recent decline in mobility?

Yes ☐ No ☒

Yes ☐ No ☐

Assistive devices used: (Check all that apply) Contacts

Eyeglasses ☐ Brace LLE ☐ Brace RLE ☐ Cane ☐

C-collar ☐ Commode ☐ Crutches ☐ Dentures ☐

Other: _____

Have you had any recent changes in ability to perform activities of daily living?

Yes ☐ No ☒

NUTRITION:

Any unintended weight loss (more than 10 pounds in the past two months)?

☐ Yes ☒ No

VACCINE:

Have you had a flu shot this season?

☐ Yes ☐ No

Have you ever had a pneumococcal v

☐ Yes ☒ No

COGNITIVE/FUNCTIONAL:

Are you deaf or hard of hearing?

☐ Yes ☐ No

Are you blind or have difficulty seeing, even wearing glasses?

☐ Yes ☐ No

Do you have difficulty concentrating, remembering or making decisions?

☐ Yes ☒ No

Do you have difficulty walking or climbing?

☐ Yes ☐ No

Do you have difficulty dressing or bathing?

☐ Yes ☐ No

Do you have difficulty doing errands alone, such as a doctor's office or shopping?

☐ Yes ☐ No

DEPRESSION SCREENING:

Over the past two weeks, have you often been bothered by:

- ☐ Little interest or pleasure in doing things
☐ Feeling down, depressed or hopeless
☐ None of the above

HOME CARE:

Current type of residence:

- ☐ Off campus without r
☐ On campus with room
☐ Off campus with roommates
☐ On campus without r
☐ Off campus with parents

Support systems: (Check all that apply)

- ☐ Spouse/significant other ☐ Parent ☐ Children ☐ Family
☐ Case manager/social worker ☐ Church/faith community
☐ Friends/neighbors ☐ Home care staff ☐ Organized suppo
☐ Shelter ☐ Therapist ☐ None ☐ Other: _____

List current medications, including birth control, over the counter medications, vitamins, etc. (include dosage and frequency):

List allergies:

Walgreens Atlanta Hwy
 Pharmacy: 334-409-0611 ☒
 Wal-Mart Atlanta Hwy 334-272-2043 ☐
 Publix Taylor Junction 334-290-4507 ☐
 CVS Atlanta Hwy 334-271-5861
 Wal-Mart 334-272-
 Other: _____