

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 11 November 2020 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: Elisabeth Aaij Birthdate: 8 January 2006

Main Phone Number: 334-549-8811 Email: _____

Local Mailing Address: 3239 Lexington Road Box or APT #: _____

City: Montgomery State: AL Zip Code: 36106

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

City: Montgomery State: _____ Zip Code: _____

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

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

Primary Physician: Dr. Doles City: Montgomery Phone #: 271-5959

Patient's Employer: AUM Work Phone #: _____

Parent's ☒ Spouse's Name: ☐ Michel Aaij Phone #: 334-549-8811

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

Emergency Contact: Michel Aaij Relationship: parenthood Phone #: 549-8811

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: Gina Newsom Aaij

Policy or Contract Number: EDU882749796 Group Number: 14000

Insurance Company's Address: 450 Riverchase Parkway East, Birmingham, AL 35244

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Elisabeth Aaij Date of Birth: 08 / 01 / 2006
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.

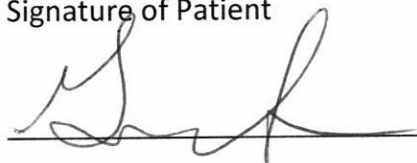
I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and 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



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

11 / 12 / 20
Day Month Year
Date of Signature

parent

Relationship to Patient

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

Name: Elisabeth Aaij Date of Birth 08 / 01 / 2006

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: Michel Aaij

☐ 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) _____ between
_____ and _____ times.

Signed: _____

Date: 11 / 12 / 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

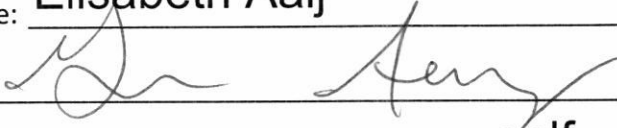
I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPAA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change 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 Thursday, 12th day of November 2020.
(day) (month) (last two digits of the year)

Print Patient's Name: Elisabeth Aaij

Signature: 

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

Name Elisabeth Aaij

 Date of birth 17 Aug 1968
Have you EVER had any of the following?

Medical: ☒ ADD/ADHD ☐ Adrenal disorders ☐ Alcohol abuse ☐ Allergies ☐ Anemia ☐ Anorexia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Bladder disease ☐ Bleeding disorder ☐ Bulimia ☐ Cancer ☐ Celiac disease ☐ Chlamydia ☐ Clotting disorder ☐ Concussion ☐ Depression ☒ Diabetes ☐ Eczema ☐ Endometriosis ☐ Eye disorders ☐ Fractures/broken bones ☐ Genital warts ☐ Gonorrhea ☐ Headaches ☐ Hearing loss ☐ Heart disease ☐ Heart murmur ☐ Hepatitis ☐ Herpes ☐ HIV/AIDS ☐ Hives ☐ HPV ☐ High cholesterol ☐ High blood pressure ☐ Mononucleosis ☐ Irritable bowel syndrome ☐ Kidney stones ☐ Malaria ☐ Multiple sclerosis ☐ Mumps ☐ Muscular dystrophy ☐ Paget's disease of bone ☐ Pneumonia ☐ PCOS ☐ Pregnancy ☐ Psoriasis ☐ Radiation therapy ☐ Seizures ☐ Sinusitis (chronic) ☐ Stroke ☐ Thyroid disease ☐ Tuberculosis ☐ Typhoid fever ☐ Ulcerative colitis ☐ Ulcers ☐ Chicken pox	Anesthesia History: ☐ Difficult intubation ☐ Malignant hyperthermia ☐ Pseudocholinesterase deficiency ☐ Spinal headache	☒ I've had NO significant health problems
Surgical: ☐ Adenoidectomy ☐ Appendectomy ☐ Cholecystectomy ☐ Ear tubes ☐ Knee ACL tear ☐ Knee arthroscopy ☐ Organ transplant ☐ Ovarian cyst removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight loss surgery ☐ Other surgical history: 		

Family History:

	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 cardiac arrest
Mother	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ Adopted ☐ Family history unknown

AUM Student Health Services - Confidential Medical History Form

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: _____

What is your gender?

- ☒ Female
☐ Male
☐ Transgender
☐ Other: 01

Preferred Pronoun:

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

MOBILITY:

Have you had any recent decline in mobility?

- ☐ Yes ☒ No

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

- ☐ Yes ☒ No

Assistive devices used: (Check all that apply) Contacts

- Eyeglasses ☐ Brace LLE ☐ Brace RLE ☐ Cane ☐
C-collar ☐ Commode ☐ Crutches ☐ Dentures ☐
Other: _____

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 vaccine?

- ☐ Yes ☒ No

TOBACCO USE: Packs a day: (Check one)

- ☐ Yes ☒ No ☐ 0.25 ☐ 0.5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 3 ☐ Yes ☐ No

Smokeless tobacco?

Start date: _____

Quit date: _____

Ready to quit?

- ☐ Yes ☐ No

Comments: _____

COGNITIVE/FUNCTIONAL:

Are you deaf or hard of hearing?

- ☐ Yes ☒ No

Do you have difficulty walking or climbing?

- ☐ Yes ☐ No

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

- ☐ Yes ☒ No

Do you have difficulty dressing or bathing?

- ☐ Yes ☒ No

Do you have difficulty concentrating, remembering or making decisions?

- ☐ Yes ☒ No

Do you have difficulty doing errands alone, such as visiting 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

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

2006

HOME CARE:

Current type of residence:

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

Support systems: (Check all that apply)

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

List allergies:

Walgreens Atlanta Hwy CVS Atlanta Hwy
Pharmacy: 334-409-0611 ☐ 334-271-5861 ☐
Wal-Mart Atlanta Hwy
334-272-0263 ☐ Other: _____

CVS, Zelda Road