

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 9-19-16 Are you an AUM student? ☒ YES ☐ NO Student ID # 500078899

Name: Kunisia Wallace Shine

Social Security Number: 417-39-5379 Birth Date 10-21-1991

Local Phone Number: (334) 328-0298 Alternate Number: _____

Local Address: 7400 East Drive Box Number 603

City: Montgomery State: AL Zip Code: 36117

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Dr. McLaughlin City: Montgomery Phone #: _____

Patient's Employer: AUM Housing and Residence Life Work #: (334) 306-8938

Parent's or Spouse's Name (Circle which) George Shine Phone #: (334) 328-0254

Parent's or Spouse's Employer: Renaissance Hotel Work #: (334) 481-5157

Emergency Contact: George Shine Relationship: Spouse Phone #: ←

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 BCBS Name on Card George Shine

Policy Number PPA684131779 Group Number 45716

Insurance Company Address 450 Riverchase Parkway East
Birmingham, AL 35244

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Thanesia Shine Date of Birth 10/21/91

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 medication 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.

Thanesia Shine
Signature of Patient

09/19/16
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

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

Name: Maresia Shine

Date of Birth: 10/21/91

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) 328-0298

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) Any day between (time) 2pm-5pm

Signed: Maresia Shine Date: 9/19/16