

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 12-8-2020 Are you an AUM Student? Yes ☒ No ☐ S-Number: _____

Name: Amelia Louise Robbins Preferred: Amelia Birthdate: 10-23-03

Main Phone Number: 334-322-3201 Email: brobbins5287@gmail.com

Local Mailing Address: 103 Poplar Ct Box or APT #: _____ City: Prattville State: AL Zip Code: 36066

Permanent/Home Address: 103 Poplar Ct Box or APT #: _____ City: Prattville State: AL Zip Code: 36066

Marital Status: Single Married Divorced Widowed Other: _____

Sex: Male Female Gender: Male Female

Primary Physician: C. Wood City: Montgomery Phone #: 334-272-1799

Patient's Employer: _____ Work Phone #: _____

Parent's Spouse's Name: Bradley Robbins Phone #: 334-322-3201

Parent's or Spouse's Employer: AUM Phone #: 334-244-3345

Emergency Contact: Sadie Robbins Relationship: Mother Phone #: 334-462-5338

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: BC/BS PEELIP Name on Card: Sadie M Robbins

Policy or Contract Number: EDU 852227453 Group Number: 14000

Insurance Company's Address: 450 Riverchase Pkwy E Birmingham, AL 35244-2858

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Amelia L Robbins Date of Birth: 10 / 23 / 03
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.

Amelia Robbins

Signature of Patient

12 / 8 / 20
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: _____ Date of Birth ____/____/____

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: Bradley & Sadie Robbins (Parents)

☐ 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) - 322 - 3201 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) Any between
_____ and _____ times.

Signed: Amelia Robbins

Date: 12/8/20

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 8 day of Dec 20 20.
(day) (month) (last two digits of the year)

Print Patient's Name: Amelia L Robbins

Signature: Amelia Robbins

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

AUM Student Health Services - Confidential Medical History Form

Name Amelia L Robbins Date of birth 10-23-03 Have you **EVER** had any of the following?

Medical:

- | | | |
|--|---|--|
| ☐ ADD/ADHD | ☐ Endometriosis | ☐ Multiple sclerosis |
| ☐ Adrenal disorders | ☐ Eye disorders | ☐ Mumps |
| ☐ Alcohol abuse | ☐ Fractures/broken bones | ☐ Muscular dystrophy |
| ☐ Allergies | ☐ Genital warts | ☐ Paget's disease of bone |
| ☐ Anemia | ☐ Gonorrhea | ☐ Pneumonia |
| ☐ Anorexia | ☐ Headaches | ☐ PCOS |
| ☐ Anxiety | ☐ Hearing loss | ☐ Pregnancy |
| ☐ Arthritis | ☐ Heart disease | ☐ Psoriasis |
| ☐ Asthma | ☐ Heart murmur | ☐ Radiation therapy |
| ☐ Bladder disease | ☐ Hepatitis | ☐ Seizures |
| ☐ Bleeding disorder | ☐ Herpes | ☐ Sinusitis (chronic) |
| ☐ Bulimia | ☐ HIV/AIDS | ☐ Stroke |
| ☐ Cancer | ☐ Hives | ☐ Thyroid disease |
| ☐ Celiac disease | ☐ HPV | ☐ Tuberculosis |
| ☐ Chlamydia | ☐ High cholesterol | ☐ Typhoid fever |
| ☐ Clotting disorder | ☐ High blood pressure | ☐ Ulcerative colitis |
| ☐ Concussion | ☐ Mononucleosis | ☐ Ulcers |
| ☐ Depression | ☐ Irritable bowel syndrome | ☐ Chicken pox |
| ☐ Diabetes | ☐ Kidney stones | |
| ☐ Eczema | ☐ Malaria | |

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:

Wisdom teeth removal

Family History:

	Alcohol abuse	Clotting disorder	Breast cancer	Colon cancer	Melanoma cancer	Other cancer: <u>Thyroid</u>	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

December 2018



AUBURN
MONTGOMERY

Name Amelia L Robbins

Date of birth 10-23-03 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: _____

What is your gender?

- ☒ Female
☐ Male
☐ Transgender
☐ Other: _____

Preferred Pronoun:

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

ABUSE HISTORY:

As is a problem in many families, we ask these questions to ALL patients. & all that apply.

Verbal abuse:

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

Please check 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?

No ☒ Yes☐ Male

Partners:

☐ Female☐ Both

Date of last Pap test: _____

Normal: ☐ Yes

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: _____

Comments: _____

Ready to quit?

☐ Yes ☐ No

December 2018

**AUBURN**
MONTGOMERY

Name

Amelia L Robbins

Date of birth

10-23-03

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

Have you had any recent decline in mobility?

Yes ☒ No

Do you have a history of falls?

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)

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? pneumococcal vaccine?

☐ Yes ☒ No

Have you ever had a

☐ 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 visiting a doctor's office or shopping?

☐ Yes ☒ No

Friends/neighbors

Home care staff

Organized support group

S Shelter

Therapist

None

Other: _____

List allergies:

Walgreens Atlanta Hwy

CVS Atlanta Hwy

Pharmacy:

Target CVS Prattville

334-409-0611

334-271-5861

Wal-Mart Atlanta Hwy

334-272-

0263

Other: _____

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.):

HOME CARE:

Off campus without roommates

Current type of residence:

On campus with roommates

Off campus with roommates

On campus without

roommates Off campus with parents

Support systems: (Check all that apply)

Spouse/significant other

Parent

Children

Family members

C Case manager/social worker

Church/faith community