

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 13/01/2021 Are you an AUM Student? ☒ Yes ☐ No S-Number: 500387164

Name: IVY NELLY KIATHIRA MBOCUA Preferred: IVY Birthdate: 27/08/2001
- imbocua@aum.edu

Main Phone Number: +1 (774) 253 92-57 Email: - nelliewaithira8@gmail.com

Local Maining Address: 20 warner AVENUE Box or APT #: 3G

City: WORCESTER State: Massachusetts Zip Code: 01604

Permanent/Home Address: RiverPark Estate, ATHI RIVER Box or APT #: 00 Hse: 096

City: MACHAKOS State: KENYA Zip Code: 00204

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

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

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: _____ Work Phone #: _____

Parent's ☒ Spouse's Name: ☐ CAROLINE KIATHIRA MBOCUA Phone #: +254733853414

Parent's or Spouse's Employer: SELF-EMPLOYED Phone #: +254729483414

Emergency Contact: NELLY MUCHAI Relationship: GRANDPARENT Phone #: +1 (508) 797 7585

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: _____ Name on Card: _____

Policy or Contract Number: _____ Group Number: _____

Insurance Company's Address: _____

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: IVY NELLY KATHIRA MBOCUA Date of Birth: 27 / 06 / 2001
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

13 / 01 / 2021
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: IVY NELLY KATHIRA MBOCUA Date of Birth 27 / 08 / 2001

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: GRAND PARENT

☐ 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: (774)-253-9257

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) ALL WEEK between
8:00 am and 10:00 PM times.

Signed: 

Date: 13 / 01 / 2021

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 13 day of 01 2021.
(day) (month) (last two digits of the year)

Print Patient's Name: IVY NELLY WAITHIRA MBOCUA

Signature: 

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

Name WY NELLY WATHIRA MBOCUA Date of birth 27/08/2001

 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 ☐ Pseudochoolinesterase 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

Name IVY NELLY WAITHIRA MBOCUADate of birth 27/08/2001Have 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 ☒

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**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**HOME CARE:**

Current type of residence:

☐ Off campus with roommates☐ Off campus with parents☐ Off campus without roommates☒ 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 current medications (including birth control, over the counter medications, vitamins, etc.):

→ Tylenol Tablets (to reduce head)
aches)→ Vitamin C drops→ Vitamin B12 Tablets→ Fish oil Tablets

List allergies:

Walgreens Atlanta Hwy

CVS Atlanta Hwy

Pharmacy: 334-409-0611 ☐334-271-5861 ☐

Wal-Mart Atlanta Hwy

334-272-0263 ☐

Other: _____