

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 4-14-17 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Amanda L. Reed

Social Security Number: 420-199938 Birth Date: 07-07-1980

Local Phone Number: 334-318-9437 Alternate Number: _____

Local Address: 86736 Jakefield Dr. Box Number _____

City: Montgomery State: AL Zip Code: 36117

Permanent Address: 6736 Jakefield Dr.

City: Montgomery State: AL Zip Code: 36117

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Nazarena City: Montgomery Phone #: 286-2390

Patient's Employer: Baptist Health Work #: 286-2843

Parent's or Spouse's Name (Circle which) _____ Phone #: _____

Parent's or Spouse's Employer: _____ Work #: _____

Emergency Contact: Donna Bradley Relationship: Friend Phone #: 334-558-8495

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☒ Other Previous Student

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 Viva Health Name on Card Amanda L Reed

Policy Number 00150542 Group Number MONTO1

Insurance Company Address Viva Health / Claims Dept

P.O. Box 55926, Birmingham, AL 35255

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 11-7-12 Are you an AUM student? ☒ YES ☐ NO Student ID # S00198008

Name: Amanda L. Reed

Social Security Number: 420-19-9938 Birth Date: 8-7-80

Local Phone Number: 334-318-⁹⁴³⁷1466 Alternate Number: _____

Local Address: 6736 Jakesfield Drive Box Number PO Box 242293 Montgomery AL 36124

City: Montgomery State: AL Zip Code: 36117

Permanent Address: same as Above

City: _____ State: _____ Zip Code: _____

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

Sex: Male ☐ ☒ Female (Please Circle)

Primary Physician: May City: Montgomery Phone #: 334-288-1950

Patient's Employer: Baptist Health Work #: 334-286-2843

Parent's or Spouse's Name (Circle which) _____ Phone #: _____

Parent's or Spouse's Employer: _____ Work #: _____

Emergency Contact: Pamela Thawes Relationship: Aunt Phone #: 334-277-2016

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.

CONSENT FOR TREATMENT

I am requesting care for myself or my above named dependent and give my consent for treatment. I am responsible for all fees for services incurred at the Student Health Center (Nursing Care Center).

Signature X _____

Signature of patient or parent/guardian, if patient is a minor.

SERVICES CONSENT FORM

NAME: _____

DATE OF BIRTH: _____

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: *[Signature]*
DATE: _____

SIGNATURE: _____
DATE: _____

[Initials] SIGNATURE: *[Signature]*
DATE: 11-16-12

SIGNATURE: _____
DATE: _____

SIGNATURE: *[Signature]*
DATE: 3-27-13

SIGNATURE: _____
DATE: _____

[Initials] SIGNATURE: *[Signature]*
DATE: 4-23-13

SIGNATURE: _____
DATE: _____

SIGNATURE: *[Signature]*
DATE: 8-29-14

SIGNATURE: _____
DATE: _____

SIGNATURE: *[Signature]*
DATE: 8-22-14

SIGNATURE: _____
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**AUM Student Health Services
Medical Information Release Form
(HIPAA Release Form)**

Name: Amanda L Reed Date of Birth: 08 / 07 / 1980

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: _____

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) anytime between (time) _____

Signed: Amanda Reed Date: 08 / 07 / 1980

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 involved 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 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 to 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 22 day of September 20 14.

Print Patient Name Amanda L. Reed

Signature Amanda Reed

Relationship to Patient _____

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 10-9-18 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Amanda Reed

Social Security Number: 420-19-9938 Birth Date: 8-7-1980

Local Phone Number: 334-318-9437 Alternate Number: same as previous

Local Address: 6736 Lakefield Drive Box Number _____

City: Montgomery State: AL Zip Code: 36117

Permanent Address: Same as above

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☒ Female ☐

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

Patient's Employer: Baptist Health Work #: 334-286-2843

Parent's or Spouse's Name (Circle which) _____ Phone #: _____

Parent's or Spouse's Employer: _____ Work #: _____

Emergency Contact: Dana Bradley Relationship: Friend Phone #: 334-558-8495

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☒ Other Dr. Dally

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 _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

Patient name: Amanda Reed

Date of birth: 08/07/1980
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	☐	☒	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☒	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☒	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☒	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☒	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☒	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☒	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	☐	☒	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☒	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☒	☐

Form completed by: Amanda L. Reed

Date: 10-9-18

Form reviewed by: _____

Date: _____

Did you bring your child's immunization record card with you?

yes ☐ no ☒ But on file here

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

Technical content reviewed by the Centers for Disease Control and Prevention

IMMUNIZATION ACTION COALITION Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (1/15)

Revised April 2015