



AUBURN UNIVERSITY
AT MONTGOMERY

WARHAWK HEALTH SERVICES

Are you an AUM Faculty or Staff member? ☒ Yes ☐ No Are you an AUM Student? ☐ Yes ☐ No

If yes, please select the semester you are currently enrolled: ☐ Fall ☐ Spring ☐ Summer

How did you hear about Warhawk Health Services? ☐ Friend ☒ Faculty/Staff ☐ Orientation ☐ Flyer Other: _____

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 2/3/21 Student Number: _____ Birthdate: 10-30-1963
Last Name: Knigge First Name: Pia Preferred: _____
Phone Number: 334 546 2829 Email: pknigge@aum.edu
Local Mailing Address: 8309 Carrington Ct Box or APT#: 137
City: Mgm. State: AL Country: Mgm Zip Code: 36117
Gender: ☐ Male ☒ Female ☐ Transgender Sex: ☐ Male ☒ Female Marital Status: ☐ Single ☐ Married ☒ Divorced ☐ Widowed ☐ Other
Ethnicity: ☐ Hispanic or Latino ☒ Not Hispanic or Latino Race: ☐ Indian or Alaska Native ☐ Asian ☐ African American ☒ Caucasian ☐ Native or Pacific Islander
Primary Physician: Dr. Brian Shickland City: Mgm State: AL Phone Number: 334 - 286 2900
Emergency Contact: Anika Hutton Relationship: daughter Phone Number: 334 549 8070
Emergency Contact: Monica Burgher Relationship: friend Phone Number: 334 - 294 1134

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.

Primary Insurance Company: BCBS of AL Policy or Contract Number: QAU804262052
Group number: 37655 Name on Insurance Card: PIA A KNIGGE
Relationship: self Policy Holder Date of Birth: 10/30/1963
Policy Holder's Employer: Auburn Univ. Phone Number: _____
Insurance Company's Address: 450 Riverchase Parkway East, AL 35244

Secondary Insurance Company: _____ Policy or Contract Number: _____

Group number: _____ Name on Insurance Card: _____

Relationship: _____ Policy Holder Date of Birth: _____

Policy Holder's Employer: _____ Phone Number: _____

Insurance Company's Address: _____

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.

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: Pia A. Lype Date: 02/03/2021
Print Patient's Name: Pia A. Knigge
Relationship to Patient (if you are the patient, write "self"): self

Warhawk Health Services
Medical Information Release Form (HIPAA Release Form)

Name: Pia Knigge Date of Birth 10/30/1963

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:

Name: Anika Hutton Phone: 334 549 8070 Relationship: daughter

Name: Monica Burgher Phone: " 294 1134 Relationship: friend

Name: Dr. Strickland Phone: " 286 2990 Relationship: primary physician

Name: _____ Phone: _____ Relationship: _____

☐ 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)-546-2829

If unable to reach me:

☒ Please send me an email plknigge@aum.edu ☐ Please leave me a message to return your call
☒ Please leave me a detailed message ☐ Other

The best time to reach me is:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☒ Morning ☐ Early Afternoon ☒ Late Afternoon ☐ Anytime

Signature: Pia Knigge

Date: 02/03/21



Confidential Medical History Form

Name: Pia Knigge

DOB: 10/30/1963

Have you EVER had any of the following?

HEENT: ☐ Sinus Infections ☐ Strep ☐ Mono ☒ Seasonal Allergies ☐ Hearing loss Respiratory: ☐ Pneumonia ☐ Bronchitis ☐ Asthma ☐ COPD Cardiac: ☒ Hypertension ☒ High cholesterol ☐ Heart disease ☒ Heart murmur Hematology: ☐ Anemia ☐ Blood clots ☐ Sickle Cell Disease/Trait ☐ Cancer: ☐ _____	GI: ☐ Irritable Bowel Syndrome ☐ Ulcerative Colitis ☐ Crohn's disease ☐ Diverticulitis ☐ GERD/Reflux GU: ☐ UTI ☐ Kidney Stones ☐ Endometriosis ☐ Gonorrhea ☐ Chlamydia ☒ Herpes ☐ HPV Endocrine: ☐ Diabetes ☐ Hypothyroidism ☐ Grave's disease ☐ PCOS Other: ☐ _____ ☐ _____	Psych: ☐ ADHD/ADD ☐ Anxiety ☒ Depression ☐ Bipolar ☐ Schizophrenia ☐ Anorexia ☐ Bulimia Neurology: ☐ Migraines ☐ Stroke ☐ Seizures ☐ Multiple Sclerosis Infectious Disease: ☐ HIV/AIDS ☐ Syphilis ☐ TB ☐ Hepatitis Integumentary: ☐ Eczema ☐ Psoriasis	☐ No significant health problems Surgeries: ☒ Tonsils & Adenoids ☐ Hysterectomy ☒ Appendectomy ☐ Cholecystectomy ☒ Other: <u>G-Secton</u> ☒ <u>ACL</u> ☐ _____ ☐ _____ ☐ _____
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Family History						
	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes	✓				✓	
Heart Disease	✓				✓	
Stroke		✓			✓	
High Cholesterol	✓				✓	
Thyroid problems		✓		✓		
Cancer (List type)					✓ colon both	
Depression		✓		✓	✓	
Alcoholism						



☒ **Smoke:** if so, how many packs per day? 1 pd How many years? 15 yrs Quit in 2000
☒ **Alcohol:** if so, how much and how often? ~ 1 glass of red wine 3-4 times a
☐ **Drugs:** if so, how much and how often? What type? → work

☒ Off campus w/o Roommates

☐ Other: _____

Zyntec

Other: