

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 8/21/15 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Diane R. Smith

Social Security Number: 416-72-2814 Birth Date: 3/14/47

Home Phone Number: (251) 961-1260 (cell) Alternate Number: (251) 284-0617

Local Address: 9571 Bayview Dr. Box Number: _____

City: Lillian State: Al Zip Code: 36549

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Dr. James Pace City: Lillian Phone #: (251) 962-4111
Al

Patient's Employer: _____ Work #: _____

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

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

Emergency Contact: J. Bert Smith Relationship: husband Phone #: (251) 504-8900

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 _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

AUM STUDENT HEALTH SERVICES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 9/25/2019 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____
Name: Diane R. Smith Birthdate: 3/14/47
Main Phone Number: (251) 284-0617 Email: smithdiane365@gmail.com
Local Mailing Address: 9571 Bayview Dr. Box or APT #: _____
City: Lillian State: Al Zip Code: 36549
Permanent/Home Address: same Box or APT #: _____

City: _____ State: _____ Zip Code: _____

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

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

Primary Physician: Wm. Ferron City: Fairhope, Al Phone #: (251) 990-1740

Patient's Employer: _____ Work Phone #: _____

Parent's ☐ Spouse's Name: ☒ J. Bert Smith, Jr. Phone #: (251) 504-8900

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

Emergency Contact: (Above) Relationship: husband Phone #: (251) 504-8900

How did you hear about the clinic: Friend ☐ Faculty/Staff ☐ Orientation ☐ Other: former patient

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 Medicare Name on Card: Diane R. Smith

Policy or Contract Number: CMS H0 104-802 Group Number: _____

Insurance Company's Address: 450 Riverchase Pkwy E. - B'ham, Al

AUM Student Health Services - Travel Health History

Date: 09/25/19 Name: Diane R. Smith

1. What is the reason for your visit today? Typhoid booster
2. List allergies you have to medicines, foods or iodine: _____

3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): Setratine, Prilosec,
Tums, Magnesium,
4. Have you had any of the following? (Check if this applies to you):
Heart Disease ☐ Stomach/Gastrointestinal Disease ☐
Kidney Disease ☐ Diabetes/Sugar ☐
5. Are you immunocomprised? (Is there a problem with your immune system)
Yes ☐ No ☐
Thymus Disorder (Myasthenia gravis, Thymoma, Thymectomy) ☐
Spleen removed ☐ Transplant recipient ☐
Cirrhosis of the liver ☐ Cancer ☒ HIV ☐
6. How often do you drink beer, wine, wine cooler or liquor?
Never ☐ Rarely ☒
1-2 times a week ☐ 3-4 times a week ☐ 5 or more times a week ☐
7. Where are you going on your trip? Kenya
8. How long is your trip? Months _____ Days 10
9. When are you leaving on your trip? Nov. 7, 2019

For Females Only

- A. Date of your last period? _____ Have you had a hysterectomy? Yes ☒ No ☐
- B. Are you currently pregnant? Yes ☐ No ☐ Due date: _____
- C. Do you plan to become pregnant in the next 3 months? Yes ☐ No ☐
- D. Are you breastfeeding? Yes ☐ No ☐

AUM STUDENT HEALTH SERVICES

CONSENT FOR SERVICES FORM

Patient Name: Diane R. Smith Date of Birth: 03/14/47
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.

Diane R. Smith

Signature of Patient

09/25/19
Day Month Year

Date of Signature

Signature of Legal Representative (if patient is unable to sign)

Relationship to Patient

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 25 day of Sept 2019.
(day) (month) (last two digits of the year)

Print Patient's Name: Diane R. Smith

Signature: Diane R. Smith

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

Form (HIPPA Release Form)

Name: Diane R. Smith 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: J. Bert Smith, Jr.

Child(ren): Ross B. Smith

☐ 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: (251)-284-0617

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) _____ between _____ and _____ times.

Signed: Winnie P. Smith

Date: 09/25/19