

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 08/16/17 Are you an AUM student? ☒ YES ☐ NO Student ID # 00345323

Name: Antaira Jones

Social Security Number: 593-71-7060 Birth Date: 10/10/1997

Local Phone Number: 561-932-8208 Alternate Number: _____

Local Address: _____ Box Number: _____

City: _____ State: _____ Zip Code: _____

Permanent Address: 956 SE 3rd Street

City: Belle Glade State: Florida Zip Code: 33430

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: _____ Work #: _____

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

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

Emergency Contact: Tarangelia Relationship: Mother Phone #: 561-853-6198

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: Molina Name on Card: Antaira Jones

Policy Number: 7691216076 Group Number: _____

Insurance Company Address: Molina Healthcare of Florida

8300 NW 33rd St, Suite 400 Doral, FL 33122

AUM Student Health Services
Medical Information Release Form
(HIPPA Release Form)

Name: Antaira D. Jones Date of Birth 10/10/1997

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: (561)-932-8208

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) Monday - Sunday between 11:00 am and 11 pm times.

Signed: Antaira Jones

Date: 8/16/17

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Antaira D Jones Date of Birth 10/10/1997

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 medication 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.

Antaira Jones
Signature of Patient

08/16/17
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient