



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: 6/14/21 Student Number: _____ Birthdate: 6/25/12

Last Name: Bray First Name: Ezra Preferred: _____

Phone Number: 334 782 1556 Email: braysp@gmail.com

Local Mailing Address: 410 New Providence way Box or APT#: _____

City: Pike Road State: AL Country: USA Zip Code: 36064

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: Prattville Pediatrics City: Prattville State: AL Phone Number: _____

Emergency Contact: Stephen Bray Relationship: Father Phone Number: 334 782 15

Emergency Contact: Hillary Bray Relationship: Stepmom Phone Number: 334 717 37

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: QAU 8844 7969

Group number: 37655 Name on Insurance Card: Stephen P Bray

Relationship: father Policy Holder Date of Birth: 8/2/83

Policy Holder's Employer: Aum Phone Number: _____

Insurance Company's Address: _____

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 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 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: _____

Date: _____

Print Patient's Name: _____

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



Confidential Medical History Form

Social History

- ☐ Smoke: if so, how many packs per day? No How many years? _____
☐ Alcohol: if so, how much and how often? No
☐ Drugs: if so, how much and how often? What type? No

☐ Living arrangements:

- ☐ On Campus w/ Roommates ☐ On Campus without Roommates
☐ Off Campus w/ Roommates ☐ Off Campus w/ Parents ☐ Off campus w/o Roommates

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

Sexual Orientation/Gender

Sexual Orientation?

- ☐ Heterosexual (straight)
☐ Gay or Lesbian
☐ Bisexual
☐ Other: _____

Medications

List current medications, including birth control, over the counter medications, vitamins, etc. (include dosage and frequency)

none

Allergies

none

Pharmacy

- ☐ Walmart Atlanta Hwy 334-272-2043
☐ Walmart Chantilly 334-272-7114
☐ Walgreens Atlanta Hwy 334-409-0611
☐ CVS Atlanta Hwy 334-271-5861
☐ Publix Taylor Junction 334-290-4507

Other: Publix Pike Road

334-694-5802

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

Name: Stephen Bray Date of Birth 6/25/12
Patient: Ezra Bray

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: Stephen Bray Phone: 334 782 1556 Relationship: father

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

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)-782-1556 ^{dad's}

If unable to reach me:

☒ Please send me an email ☐ 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: Stephen Bray

Date: 6/24/12



Confidential Medical History Form

Name: Erza Bray

DOB: 6/25/12

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: _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____
---	--	--	--

Family History						
	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes						
Heart Disease						
Stroke						
High Cholesterol						
Thyroid problems						
Cancer (List type)						
Depression						
Alcoholism						