

AUM NURSING CARE CENTER

PATIENT INFORMATION (Print Please)

Date: 4/18/07
Name: Julie C Freeman
Student ID #: 559841394 Birth Date: 04/27/1957
Local Phone Number: 334-270-9533 Alternate Number: 334-312-2095
Local Address: 9240 Gainswood Box Number: _____
City: Montgomery State: AL Zip Code: 36117
Permanent Address: Above
City: _____ State: _____ Zip Code: _____

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

Sex: Male ☐ Female ☒

Primary Physician: Dr. Mary Luz Fuentes City: Montgomery Phone #: 265-5577

Patient's Employer: NA Work #: _____

Parent's or Spouse's Name: (indicate which one) Michael E. Freeman Phone #: 270-9533

Parent's or Spouse's Employer: Southern Orthopedic Surgeons Work #: 613-9000

Emergency Contact: Michael E Freeman Relation Spouse Phone #: 312-2089/613-9000

How did you hear about our clinic? Friend ☐ Faculty Staff ☐ Orientation ☐ Other: Letter for EARN

INSURANCE INFORMATION

Do you have health insurance? Yes ☒ No ☐ If yes, please complete the following information.

Name of insured: Michael E Freeman Relationship to patient: Spouse

Insurance Company: BCBS of AL

Policy Number: PPA 816014434 Group Number: 48956

Insurance Company Address: 450 Riverchase Pkwy East

City: Birmingham State: AL Zip Code: 35244

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 Nursing Care Center.

Signature X: Julie C Freeman
Signature of patient or parent/guardian, if patient is a minor

Patient Bill of Rights

AUM Nursing Care Center (AUM NCC) exists primarily for the purpose of providing high quality care that meets or exceeds accepted standards for care. AUM NCC believes that each client is worthy of respect and understanding and has certain rights and responsibilities related to the care he/she receives. In accordance with this philosophy, AUM NCC wishes to advise you of the following rights and responsibilities and to assist you in understanding and exercising these rights.

As a client of AUM NCC, you have the right to:

1. Be treated with dignity, courtesy, and respect.
2. Obtain from caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
3. Know the identity of all caregivers involved in their care, as well as when those involved are students or trainees.
4. Know the immediate and long-term financial implications of treatment choices, insofar as they are known.
5. Make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and AUM NCC policy and to be informed of the medical consequences of the action. In case of refusal, the patient is entitled to other appropriate care and services or to be referred to another health care facility.
6. Receive competent, individualized quality services from AUM NCC regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, or any other category protected by law.
7. Expect confidentiality of all clinical records and access to your records on request. Information will not be released to anyone without your written consent or unless required by law.
8. Have family or guardian exercise these rights on your behalf if you are unable to do so yourself.
9. Voice grievances about care which is or is not provided, recommend policy/service changes, and make complaints without fear of reprisal or unreasonable interruption of care.

I also understand I have a responsibility to:

1. Provide accurate and complete information to AUM NCC regarding medical history and current condition and medications, and to promptly inform AUM NCC of any changes in this information.
2. Agree to accept all caregivers regardless of age, race, color, national origin, religion, sex, disability, being a qualified disabled veteran, being a qualified veteran of the Vietnam era, or any other category protected by law.
3. Participate in planning, evaluation and revising my plan of care to the degree that I am able to do so and to take responsibility for my actions and for the impact that those actions have on my health and recovery.
4. Adhere to the plan of care which I have participated in developing.
5. Treat AUM NCC staff with respect, courtesy, and consideration.

I have read and understand the above Patient Bill of Rights and agree to the contents thereof.

Patient Signature: _____

Date: _____

4/18/07

SERVICES CONSENT FORM

NAME: Julie C Freeman
DATE OF BIRTH: 4/27/1957

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: Julie C Freeman
DATE: 4/18/07

SIGNATURE: Julie C Freeman
DATE: 6/20/07

SIGNATURE: Julie C Freeman
DATE: 5/3/10

SIGNATURE: Julie C Freeman
DATE: 5/18/10

SIGNATURE: Julie C Freeman
DATE: 04/01/2011

SIGNATURE: Julie C Freeman
DATE: 6/18/12

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

SIGNATURE: _____
DATE: _____

Date 4/18/07

ADOLESCENT/ADULT HEALTH HISTORY

Name _____

1. What is the reason for your visit today? Physical requirement for the EARN Program
2. Is there anything about you and your health that we need to know? osteoporosis
3. List medicine, drugs, or food you are allergic to: Demerol
4. List any medicines or drugs you take: Premarin, Calcium
5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
 stroke

diabetes/sugar
 blood problem or disease
cancer

tuberculosis
 birth defects
 mental retardation

nerve or mental problems
 asthma
 died before age 50
 other "family" disease

~~Maternal~~ mother-hypertension, Me-Melanoma

6. Have you ever been in the hospital? yes Why? Endometriosis, hysterectomy
7. Have you ever had surgery? yes Why? hysterectomy
8. Have you ever had a serious accident? no
9. Have you had serious or recent problems with:

ears or throat ☒ NO YES
 allergies ☒ NO YES
 lung infections ☒ NO YES

cough ☒ NO YES
 thyroid ☒ NO YES
 skin problems ☒ NO YES

kidneys ☒ NO YES
 weight loss ☒ NO YES
 ulcers ☒ NO YES

gallbladder ☒ NO YES
 liver ☒ NO YES
 depression ☒ NO YES
 headaches ☒ NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? ☒ NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? ☒ NO YES
12. Have you ever smoked cigarettes or used smokeless tobacco? ☒ NO YES
 If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?
 How much smokeless tobacco do you use a day? _____
13. How often do you drink beer, wine, wine coolers, or liquor?
 Never ☒ Rarely 1-2 times a week 3-4 times a week 5 or more times a week
 If you drink beer, wine, wine coolers, or liquor, do you have:
 (less) (more) than 5 drinks a day?

14. Have you ever used marijuana, cocaine, crack or other drugs? ☒ NO YES
15. Have you ever used I.V. drugs? ☒ NO YES
16. Have you ever had a blood transfusion? ☒ NO YES
17. Do you have any tattoos? ☒ NO YES
18. Have you ever been treated for a venereal disease? ☒ NO YES
19. Have you had more than one sex partner in the past 5 years? ☒ NO YES
20. Have you ever had sex with a member of your own sex? ☒ NO YES
21. Have you had or been around anyone with hepatitis? ☒ NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? ☒ NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? 13 Date of your last period? n/a hysterectomy
 How often do you have your periods? _____ Are they regular? _____
 How many days do they last? _____
 Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? ☒ NO YES
 Do you check them regularly? ☒ YES NO
- *C. How many times have you ever been pregnant? 3 How many children are living? 2
 Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? ☒ NO YES
 Were any of your children premature? ☒ NO YES
 How old were you when your first child was born? 31
- D. Have you ever used: (circle NO/YES) birth control pills? NO ☒ YES foam? ☒ NO YES condoms? ☒ NO YES IUD? ☒ NO YES
 diaphragm? NO ☒ YES
- E. Did you have problems with any of these methods? ☒ NO YES
- F. Have you ever had an abnormal PAP smear? ☒ NO YES