

CLUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 3/2/16 Name Donald Bert Harris

1. What is the reason for your visit today immunization
2. List allergies you have to medicines, foods or iodine: none
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): statin, nasal steroid
4. Have you had any of the following: (circle if this applies to you);
Heart disease _____
Kidney disease _____
Stomach/Gastrointestinal disease _____
Diabetes/sugar _____
5. Are you immunocompromised? (Is there a problem with your immune system) Yes _____ No X
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? (Please circle)
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? Thailand
8. How long is your trip? Months 10 Days 10
9. When are you leaving on your trip? May 17

FOR FEMALES ONLY

- A. Date of your last period? _____ Have you had a hysterectomy? YES _____ NO _____
- B. Are you currently pregnant? YES _____ NO _____
What is your 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 CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 3/2/16 Are you an AUM student? YES ☒ NO ☐ Student ID # _____

Name: Donald Bert Harris

Social Security Number: 506-22-0529 Birth Date: 2/8/1951

Local Phone Number: 334-745-4074 Alternate Number: 402-730-3826

Local Address: 468 Lee Road #176 Box Number _____

City: Opelika State: AL Zip Code: 36801

Permanent Address: same

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): ☒ Male ☐ Female

Primary Physician: Commander City: Opelika Phone #: _____

Patient's Employer: Investment Professionals Work #: 334-887-9760

Parent's or Spouse's Name (Circle which) Paula Phone #: 334-745-4074

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

Emergency Contact: Paula Harris Relationship: wife Phone #: 334-745-4074

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☒ Other Doctor

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: Medicare Name on Card: Donald Bert Harris

Policy Number: _____ Group Number: _____

Insurance Company Address: _____

AUM Student Health Services 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 complete description 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 to 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 2nd day of March 20 16.

Print Patient Name Donald Bert Harris

Signature Donald Bert Harris

Relationship to Patient self

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

Name: Ronald Bert Harris Date of Birth: 2/8/1951

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: 402-730-3826

If unable to reach me:

☒ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) any time between (time) _____

Signed: Ronald Bert Harris Date: 3/2/16

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Donald Bert Harris Date of Birth 2/8/1951

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.

Donald Bert Harris
Signature of Patient

2/2/16
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient