

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 7/1/14 Are you an AUM student? YES ☐ NO ☒ Student ID # _____

Name: Lori Nielsen

Social Security Number: 550-41-0049 Birth Date 12-9-72

Local Phone Number: 702-682-3085 Alternate Number: OFFICE 244-3225

Local Address: 270 Woodhaven Ln Box Number _____

City: Wetumpka State: AL Zip Code: 36093

Permanent Address: SAME

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: DR. STEVEN SMITH City: Montgomery Phone #: _____

Patient's Employer: AUM Work #: 244-3225

Parent's or Spouse's Name (Circle which) ERIK Phone #: 702-715-0603

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

Emergency Contact: ERIK Relationship: SPOUSE Phone #: _____

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 BCBS Name on Card Lori A. Nielsen

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 HIPPA 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 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 25th day of August 20 16.

Print Patient Name LORI NIELSEN

Signature [Signature]

Relationship to Patient _____

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

Name: LOKI NIELSEN

Date of Birth: 12/9/72

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 ERIK NIELSEN

☐ 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: 3225 702-682-3085

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) _____

between (time) _____

Signed: [Signature]

Date: 8/25/2016

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name LORI NIELSEN Date of Birth 12/9/72

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.

Lori Nielsen
Signature of Patient

8/25/2016
Date of Signature

Signature of Legal Representative (if patient unable to sign)

Relationship to Patient

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Maryluz Fuentes, M.D.
(334) 286-2390
DEA #BF 6451520
AL #24127

Name

Rain Nunez

Date

7-1-14

Address

R

Triamterene 21/2 con

80 mg
3-4 times per day BID to
after meals

M.D. or C.R.N.P.

Product Selection Permitted

Label all prescriptions

M.D. or C.R.N.P.

Refill: 1 2 3 5 PRN NR

Dispense As Written

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 7/1/14 TIME: 9:30

PT. HISTORY REVIEWED / UPDATED 1

PATIENT NAME: Lori Nielsen

DOB: _____ AGE: _____

PRESENT COMPLAINT: Fire ant bites and last time was treated w/ triamcinolone and is almost out. Has reactions. Had west Nile. Has 27 bites on (R) fore arm. Was bitten Saturday.

MEDICATIONS: vitamins, OTC

LMP: 6/8/14

Temp	Pulse	Resp	B/P	HT	WT	Allergies
99.1			136/94			NKMA

INITIAL VISIT

Skin	<u>multiple erythematous</u>	RETURN VISIT
Sinuses	<u>depressed paranasal on (R)</u>	
Ears	<u>normal</u>	
Eyes	<u></u>	
Nose		
Throat		
Neck/Back		
Heart		
Lungs		
Abdomen		
GU/GI		
Extremities		

DIAGNOSIS:

Fire ant bite

TESTS

RESULTS

PLAN:

Apply Triamcinolone
1% cream to area
BID for 3-4 days

CALL BACK:

7/2/14 - Corresponded to pt. States
arm is looking better each time
she raps it. Will continue cream
x etc if necessary.

PRACTITIONER
SIGNATURE: _____

STAFF
SIGNATURE: J. Gen

AUDIT DATE: _____ COMMENTS: _____

PHYSICIAN SIGNATURE: _____

AUM NURSING CARE CENTER
JOLESCENT/ADULT HEALTH HISTORY

Date

7/1/14

Name

Lois Nielsen

1. What is the reason for your visit today? Five ant bites
2. Is there anything about you and your health that we need to know? _____

- *3. List medicine, drugs, or food you are allergic to: _____
- *4. List any medicines or drugs you take: Vitamins

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

6. Have you ever been in the hospital? ✓ Why? tonsils removed
7. Have you ever had surgery? ✓ Why? tonsils removed / dental surgery
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? 12 Date of your last period? June 8th 2014
- How often do you have your periods? 4 Monthly Are they regular? YES
- How many days do they last? 3-5
- 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? 0 How many children are living? _____
- 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? _____
- 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