

# AUM STUDENT HEALTH CENTER

## PATIENT INFORMATION (PLEASE PRINT)

Date: 9/16/16 Are you an AUM student? YES ☒ NO ☐ Student ID # \_\_\_\_\_

Name: Tammy Hudson

Social Security Number: 559 79 1941 Birth Date: 1/16/70

Local Phone Number: 334 270 0079 Alternate Number: 334 398 2448

Local Address: 1111 Foggy Hollow Tr Box Number \_\_\_\_\_

City: Fitzpatrick State: AL Zip Code: 36029

Permanent Address: Same

City: ↓ State: ↓ Zip Code: ↓

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Dr. Yates City: Mont. Phone #: 262-0342

Patient's Employer: Bell Road Family Dentistry Work #: 395-6695

Parent's or Spouse's Name (Circle which) Dr. Dan Hudson Phone #: 398 0285

Parent's or Spouse's Employer: Bell Road Family Dentistry Work #: 395-6695

Emergency Contact: Dan Hudson Relationship: Spouse Phone #: 398 0285

How did you hear about the Clinic? Friend ☐ Faculty/Staff ☐ Orientation ☒ Other Eastern Hills Baptist Church

## 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 Freedom Life Ins. Co. Name on Card Tammy Hudson

Policy Number 52M0864200 Group Number \_\_\_\_\_

Insurance Company Address PO Box 1628 Addison, TX 75001-1628

Phone # 866-745-8744 or 800-387-9027

**AUM STUDENT HEALTH CENTER**  
**CONSENT FOR SERVICES FORM**

Patient Name Tammy Hudson Date of Birth 1/16/70

**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.

Tammy Hudson  
Signature of Patient

9, 16, 16  
Date of Signature

\_\_\_\_\_  
Signature of Legal Representative (if patient unable to sign)

\_\_\_\_\_  
Relationship to Patient

## 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 16 day of Sept 2016

Print Patient Name Tammy Hudson

Signature Tammy Hudson

Relationship to Patient Self

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

Name: Tammy Hudson Date of Birth: 1 / 16 / 70

### 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 Dan Hudson
- ☒ Child(ren) Taylor & Mikayla Zimmerman, Bethany Hudson
- ☒ Other Mother - Janice E. Stowe

☐ 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: 398-2448

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) Anytime between (time) \_\_\_\_\_

Signed: [Signature] Date: 9 / 16 / 16

TRAUM STUDENT HEALTH CENTER  
TRAVEL HEALTH HISTORY

Date 9/16/16 Name Tammy Hudson

1. What is the reason for your visit today Haiti Vaccinations / medications
2. List allergies you have to medicines, foods or iodine: \_\_\_\_\_
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): loesterin, Clonopin (at bedtime) tramadol  
1 x a day (as needed), claritin 10 mg 1 x a day
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 ☒
  - 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? Haiti
8. How long is your trip? Months \_\_\_\_\_ Days 10 days
9. When are you leaving on your trip? Oct 14

FOR FEMALES ONLY

- A. Date of your last period? Aug 30 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 ☒

