



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: 9-9-22 Student Number: \_\_\_\_\_ Birthdate: 6-8-1981

Last Name: Hayes First Name: Dorothy Preferred: \_\_\_\_\_

Phone Number: 205 683 1313 Email: hopehayes@gmail.com

Local Mailing Address: 615 Karen Rd Box or APT#: \_\_\_\_\_

City: Montgomery State: AL Country: USA Zip Code: 36109

Permanent/ Home Address: \_\_\_\_\_ APT#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Gender: ☐ Male ☒ Female ☐ Transgender Sex: ☐ Male ☒ Female Marital Status: ☒ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Race: ☐ Indian or Alaska Native ☐ Asian ☐ African American ☒ Caucasian ☐ Native/Pacific Islander ☐ Other: \_\_\_\_\_

Ethnicity ☐ Hispanic or Latino ☒ Not Hispanic or Latino

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Emergency Contact: Faith Cooper Relationship: mother Phone Number: 256 490 9756

Emergency Contact: DeAnn Harrison Relationship: Friend Phone Number: 334 313 4628

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 Policy or Contract Number: 0A4877299825

Group number: 37655 Name on Insurance Card: Dorothy Hope Hayes

Relationship: Self Policy Holder Date of Birth: 6-8-81

Insurance Company's Address: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Policy or Contract Number: \_\_\_\_\_

Group number: \_\_\_\_\_ Name on Insurance Card: \_\_\_\_\_

Relationship: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_

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 Warhawk Health Services. 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: Dorothy G. Hayes Date: 9/9/2022  
Print Patient's Name: Dorothy G. Hayes  
Relationship to Patient (if you are the patient, write "self"): Self

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

Name: Dorothy Hayes Date of Birth 6/8/81

**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: Faith Cooper Phone: 256 4909256 Relationship: mother

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: (205)-683-1313

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: [Signature]

Date: 9/9/02



WARSAW  
HEALTH SERVICES

### Confidential Medical History Form

Name: Dorothy Hayes

DOB: 6-8-81

Have you EVER had any of the following?

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>HEENT:</b><br><input checked="" type="checkbox"/> Sinus Infections<br><input type="checkbox"/> Strep<br><input type="checkbox"/> Mono<br><input checked="" type="checkbox"/> Seasonal Allergies<br><input type="checkbox"/> Hearing loss<br><br><b>Respiratory:</b><br><input type="checkbox"/> Pneumonia<br><input checked="" type="checkbox"/> Bronchitis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> COPD<br><br><b>Cardiac:</b><br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> High cholesterol<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Heart murmur<br><br><b>Hematology:</b><br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Blood clots<br><input type="checkbox"/> Sickle Cell Disease/Trait<br><input type="checkbox"/> Cancer:<br><input type="checkbox"/> _____ | <b>GI:</b><br><input checked="" type="checkbox"/> Irritable Bowel Syndrome<br><input type="checkbox"/> Ulcerative Colitis<br><input type="checkbox"/> Crohn's disease<br><input type="checkbox"/> Diverticulitis<br><input type="checkbox"/> GERD/Reflux<br><br><b>GU:</b><br><input type="checkbox"/> UTI<br><input type="checkbox"/> Kidney Stones<br><input type="checkbox"/> Endometriosis<br><input type="checkbox"/> Gonorrhea<br><input type="checkbox"/> Chlamydia<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> HPV<br><br><b>Endocrine:</b><br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Hypothyroidism<br><input type="checkbox"/> Grave's disease<br><input type="checkbox"/> PCOS<br><br><b>Other:</b><br><input type="checkbox"/> <u>H. pylori</u><br><input type="checkbox"/> _____ | <b>Psych:</b><br><input type="checkbox"/> ADHD/ADD<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Bipolar<br><input type="checkbox"/> Schizophrenia<br><input type="checkbox"/> Anorexia<br><input type="checkbox"/> Bulimia<br><br><b>Neurology:</b><br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Seizures<br><input type="checkbox"/> Multiple Sclerosis<br><br><b>Infectious Disease:</b><br><input type="checkbox"/> HIV/AIDS<br><input type="checkbox"/> Syphilis<br><input type="checkbox"/> TB - <u>exp'd - now positive</u><br><input type="checkbox"/> Hepatitis<br><br><b>Integumentary:</b><br><input type="checkbox"/> Eczema<br><input checked="" type="checkbox"/> Psoriasis<br><br><input type="checkbox"/> Skin cancer | <input type="checkbox"/> No significant health problems<br><br><b>Surgeries:</b><br><input checked="" type="checkbox"/> Tonsils & Adenoids<br><input type="checkbox"/> Hysterectomy<br><input type="checkbox"/> Appendectomy<br><input type="checkbox"/> Cholecystectomy<br><input type="checkbox"/> Other: <u>Gallbladder</u><br><input type="checkbox"/> <u>Right foot fusion</u><br><input type="checkbox"/> <u>Tibial/Fibula</u><br><input type="checkbox"/> <u>ACL-PCL meniscus</u><br><input type="checkbox"/> <u>Right orbital fracture</u> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Family History

|                    | Father | Mother | Brother | Sister | Grandparent | Other                   |
|--------------------|--------|--------|---------|--------|-------------|-------------------------|
| Diabetes           |        |        |         |        | ✓           |                         |
| Hypertension       |        |        |         |        |             |                         |
| Heart Disease      | ✓      |        |         |        |             |                         |
| Stroke             |        |        |         |        | ✓           |                         |
| High Cholesterol   |        |        |         |        |             |                         |
| Thyroid problems   |        |        |         |        |             | ✓                       |
| Cancer (List type) |        |        |         |        |             | ✓ breast, stomach, lung |
| Depression         |        |        |         |        |             | skin                    |
| Alcoholism         |        | ✓      | ✓       |        |             |                         |



### Confidential Medical History Form

#### Social History

- ☐ Smoke if so, how many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_
- ☐ Alcohol if so, how much and how often? \_\_\_\_\_
- ☐ Drugs if so, how much and how often? What type? \_\_\_\_\_
- ☐ 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: \_\_\_\_\_

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

N/A

Please list allergies and reactions if known

Seasonal  
biann  
morphine

#### Pharmacy

- ☐ Walmart Atlanta Hwy
- ☐ Walmart Chantilly
- ☒ Walgreens Atlanta Hwy (at Perry Hill)
- ☐ CVS Atlanta Hwy
- ☐ Publix Taylor Junction
- ☐ Adams Copperfield
- Other: \_\_\_\_\_