



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: 9/22/2021 Student Number: NIA Birthdate: 2/23/2007
Last Name: Bicknell First Name: Stephen Preferred: _____
Phone Number: (334) 946-8712 Email: B.N.Bicknell@auburn.edu
Local Mailing Address: 2159 County Rd. 11 Box or APT#: _____
City: Prattville State: AL Country: US Zip Code: 36067
Gender: ☒ Male ☐ Female ☐ Transgender Sex: ☒ Male ☐ Female Marital Status: ☒ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Ethnicity: ☐ Hispanic or Latino ☒ Not Hispanic or Latino Race: ☐ Indian or Alaska Native ☐ Asian ☐ African American ☒ Caucasian ☐ Native or Pacific Islander
Primary Physician: Dr. Steven Allen City: Prattville State: AL Phone Number: 508-2120
Emergency Contact: Miranda Bicknell Relationship: mother Phone Number: 946-8712
Emergency Contact: Josh Walcott Relationship: step dad Phone Number: 799-5439

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 of Alabama Policy or Contract Number: 0A4885240773
Group number: 37055 Name on Insurance Card: Miranda Bicknell
Relationship: den. Policy Holder Date of Birth: 3/25/1988
Policy Holder's Employer: AUM Phone Number: (334) 244-3281
Insurance Company's Address: _____
Secondary Insurance Company: Tricare Policy or Contract Number: 630-23-3233
Group number: NIA Name on Insurance Card: Stephen D. Bicknell
Relationship: dad Policy Holder Date of Birth: 11/30/1980
Policy Holder's Employer: US Army Phone Number: _____
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 involve 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 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.

Signature:  Date: 9 / 22 / 2021

Print Patient's Name: Miranda B. (unclear)

Relationship to Patient (if you are the patient, write "self"): mother

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

Name: Stephen Richelli Date of Birth 2/23/2021

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: <u>Miranda Richelli</u>	Phone: <u>540-8712</u>	Relationship: <u>mother</u>
Name: <u>Josh Waldorf</u>	Phone: <u>799-5439</u>	Relationship: <u>step dad</u>
Name: <u>Dr. Steven Allen D</u>	Phone: <u>568-2124</u>	Relationship: <u>PCP</u>
Name: <u>Pine Level Family Care</u>	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: (334)-540-8712

If unable to reach me:

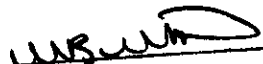
☐ Please send me an email
☒ Please leave me a detailed message

☐ Please leave me a message to return your call
☐ Other

The best time to reach me is:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☐ Morning ☐ Early Afternoon ☐ Late Afternoon ☐ Anytime

Signature: 

Date: 9/22/2024



Confidential Medical History Form

Name: Stephen Rickert

DOB: 9/22/2021

Have you EVER had any of the following?

HEENT: ☐ Sinus Infections ☐ Strep ☐ Mono ☐ Seasonal Allergies ☐ Hearing loss Respiratory: ☒ Pneumonia <i>as a child</i> ☐ Bronchitis ☐ Asthma ☐ COPD Cardiac: ☐ Hypertension ☐ High cholesterol ☐ Heart disease ☐ Heart murmur Hematology: ☐ Anemia ☐ Blood clots ☐ Sickle Cell Disease/Trait ☐ Cancer: _____ ☐ _____	GI: ☐ Irritable Bowel Syndrome ☐ Ulcerative Colitis ☐ Crohn's disease ☐ Diverticulitis ☐ GERD/Reflux GU: ☐ UTI ☐ Kidney Stones ☐ Endometriosis ☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ HPV Endocrine: ☐ Diabetes ☐ Hypothyroidism ☐ Grave's disease ☐ PCOS Other: ☐ _____ ☐ _____	Psych: ☒ ADHD/ADD ☐ Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐ Anorexia ☐ Bulimia Neurology: ☐ Migraines ☐ Stroke ☐ Seizures ☐ Multiple Sclerosis Infectious Disease: ☐ HIV/AIDS ☐ Syphilis ☐ TB ☐ Hepatitis Integumentary: ☐ Eczema ☐ Psoriasis	☐ No significant health problems Surgeries: ☐ Tonsils & Adenoids ☐ Hysterectomy ☐ Appendectomy ☐ Cholecystectomy ☐ Other: _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____
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Family History						
	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes					X	
Heart Disease					X	
Stroke					X	
High Cholesterol						X Aunt
Thyroid problems						
Cancer (List type)						
Depression						
Alcoholism						X

CMD



- ☐ On Campus w/ Roommates ☐ On Campus without Roommates ☐ Off campus w/o Roommates
☐ Off Campus w/ Roommates ☐ Off Campus w/ Parents

- ☐ Little interest or pleasure in doing things
☐ Feeling down, depressed, or hopeless
☐ None of the above

- ☒ Heterosexual (straight)
☐ Gay or Lesbian
☐ Bisexual
☐ Other: _____

NU meds.

NKA

- ☐ Walmart Atlanta Hwy 334-272-2043
- ☐ Walmart Chantilly 334-272-7114
- ☐ Walgreens Atlanta Hwy 334-409-0611
- ☐ CVS Atlanta Hwy 334-271-5861
- ☐ Publix Taylor Junction 334-290-4507

Other: Adams Praterville