

AUM STUDENT HEALTH CENTER - EMPLOYEES

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 11/28/18 Are you an AUM Student? Yes ☒ No ☐ S-Number: 500362351

Name: Pam Dent Birthdate: 8/11/60

Main Phone Number: 334-220-0779 Alternate Phone Number: _____

Local Mailing Address: 220 Daleshire PL Box or APT #: _____

City: Montg State: AL Zip Code: 36117

Permanent/Home Address: same Box or APT #: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒ Gender: Male ☐ Female ☒

Primary Physician: Eric Graves City: Montg Phone #: _____

Patient's Employer: AUM Work Phone #: 244-3794

Parent's or Spouse's Name (Circle which): _____ Phone #: _____

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

Emergency Contact: Taylor Dent Relationship: son Phone #: 334-221-0612

How did you hear about the clinic (Circle which): Friend ☐ Faculty/Staff ☒ Orientation ☐ Other: _____

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.

Insurance Company: _____ Name on Card: _____

Policy or Contract Number: _____ Group Number: _____

Insurance Company's Address: _____

AUM STUDENT HEALTH CENTER

CONSENT FOR SERVICES FORM

Patient Name: Pam Dent Date of Birth: 8 / 11 / 1960
Day Month Year

General Consent for Treatment

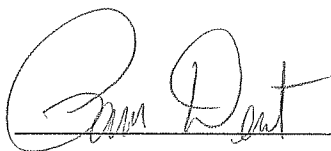
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

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 of Patient

11 / 28 / 18
Day Month Year
Date of Signature

Signature of Legal Representative (if patient is unable to sign)

Relationship to Patient

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

Name: Pam Dent Date of Birth 8, 11, 60

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): Taylor Dent

☐ 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: (334)- 220 - 6179

If unable to reach me:

☒ you may leave me a detailed message

☐ please leave a message asking me to return your call

☐ other: _____

The best time to reach me is (day or days) any between _____ and _____ times.

Signed: Pam Dent

Date: 11 / 28 / 18

AUM Student Health Services PATIENT HIPPAA 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 (HIPPA). 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 HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. 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.

Signed this 28th day of November 2018.
(day) (month) (last two digits of the year)

Print Patient's Name: Pam Dent

Signature: Pam Dent

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

NAME:

Pam Dene

Date:

11/26/18

FAMILY HISTORY: Indicate illnesses in blood relatives. Check those that apply.

- | | | |
|--|---|---|
| ☐ Anemia | ☐ Diabetes (type 1 or 2) | ☒ Migraines/headaches |
| ☐ Bleeding or clotting abnormally | ☐ Heart disease | ☐ Stroke |
| ☐ Breast disease | ☒ High cholesterol | ☐ Thyroid disorder (Hypo or Hyper) |
| ☐ Cancer | ☒ High blood pressure | ☐ Arthritis |
| ☐ Prostate | | ☐ Rheumatoid |
| ☐ Skin | | ☐ Osteoarthritis |
| ☐ Colon | | |
| ☒ Lung mother | | ☐ Connective Tissue |
| ☐ Breast | | ☐ Lupus |
| ☐ Other | | Other: _____ |

Pharmacy Information:Please List all current medications below

(include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc.)

Name of Medication	Dosage (Mg)	Times per Day	Dates of Use	Side Effects (if any)	Prescribing Physician
indural		1	3 daily		
protonix		1			
nortriptolene		1			
synthroid		1			

Preferred pharmacy?

AUM - Tiger - Pharmacy

Phone #:

For Women:**GYNECOLOGICAL HISTORY:**Do you a period every month? __ Yes ☒ __ No

Number of days of flow: _____

Menstrual cramps: __ mild __ moderate __ severe __ normal

Date of last PAP smear: 11/5 Last PAP smear results: good Have you ever had an abnormal Pap smears? __ Yes ☒ __ No

If yes, explain clinical history (including test location, date, what was done) for any abnormal PAP smear?

Are you presently trying to become pregnant or will be trying soon? __ Yes ☒ __ NoHave you had a mammogram? ☒ Yes __ No

If applicable, indicate the date and result of your last mammogram:

1/2018 - fine

NAME: Pam Donf Date: 11/28/18

AUM Student Health Services Comprehensive Health History Form

Medical History: Do you have, or have you ever had any of the following? (check all that apply)

Cardiovascular ☒ High Blood Pressure ☒ Congestive Heart Failure ☐ Atrial Fibrillation ☐ Other: _____	Gastrointestinal ☐ Ulcers ☐ Pancreatitis ☐ Irritable Bowel ☐ Colitis ☐ Crohn's ☒ Reflux	Respiratory ☐ Asthma ☐ COPD / Emphysema ☐ TB (Tuberculosis)	Immunologic / Viral ☐ HIV / AIDS ☐ Herpes ☐ Epstein-Barr	Endocrine ☐ Diabetes ☒ Thyroid (Hyper/Hypo)
Neurologic ☐ Stroke ☐ Parkinson's Disease ☐ Alzheimer's / Dementia ☐ Seizure Disorder ☒ Headaches ☒ Migraines ☐ Sleep Apnea ☐ Fibromyalgia ☐ Insomnia (Can't Sleep)	Kidney & Urologic ☐ Kidney Stones ☐ Enlarged Prostate ☐ Urinary Tract Infections Liver ☐ Gallstones ☐ Cirrhosis Hepatitis: ☐ A ☐ B ☐ C	Reproductive ☐ Hysterectomy ☐ Contraceptives Used: Menstrual Cycle: ☐ Regular ☐ Irregular ☐ Genital Disease(s) ☒ Infertility ☐ Erectile Dysfunction	Ear/Nose/Throat/Eye ☒ Glaucoma ☐ Cataract ☐ Chronic Sinus Infection ☐ Upper Airway Infections ☐ Dizziness	Other ☐ Cancer (explain): ☐ Anemia ☐ High Cholesterol ☐ Sickle Cell ☐ On Anticoagulants ☐ Chronic Pain (explain): ☐ Skin Conditions (explain):

Review of Systems: (check all SYMPTOMS that apply)

Systemic Weight: ☐ gain ☐ loss ☐ Fever ☐ Chills ☐ Night Sweats ☐ Pain	Gastrointestinal Appetite: ☐ good ☐ fair ☐ poor ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Rectal Bleeding ☐ Abdominal Pain	Cardiovascular ☐ Chest Pain ☐ Palpitations (irregular heartbeat)	Skin ☐ Dry Skin ☐ Itchy Skin ☐ Peeling Skin ☐ Scaling Skin ☐ Discolored Skin ☐ Rash(es) on Skin	Endocrine ☐ Excessive Thirst ☐ Heat Intolerance ☐ Cold Intolerance ☐ Excessive Sweating ☐ Feelings of Weakness
Neurologic / Head ☐ Involuntary Movements ☐ Speech Problems ☐ Paralysis ☐ Dizziness ☐ Fainting ☐ Vertigo ☐ Confusion ☐ Memory Loss ☐ Limb Weakness ☐ Balance Problems ☐ Tingling ☐ Numbness ☐ Headache ☐ Sinus Pain	Genitourinary ☐ Blood in Urine ☐ Odor in Urine ☐ Frequent Urination ☐ Difficult Urination ☐ Small Amount of Urine ☐ Night Time Urination ☐ Incontinent of Urine	Pulmonary ☐ Difficulty Breathing ☐ Short of Breath ☒ Dry Cough ☐ Productive Cough ☐ Cough with Blood ☐ Wheezing	Eye and Ears-Nose-Throat ☐ Vision ☐ Diplopia ☐ Blurry Vision ☐ Red Eyes ☐ Hearing Loss ☐ Tinnitus (ringing in ear) ☐ Epistaxis (nose bleeds) ☒ Nasal Itching ☐ Sore Throat ☐ Mouth Sores ☒ Mouth Dryness ☒ Runny Nose	Musculoskeletal ☐ Back Pain ☐ Muscle Aches ☐ Muscle Cramps ☐ Joint Pain - localized ☐ Joint Swelling - localized ☐ Joint Stiffness - localized ☐ Arthritis Pain

Please list all prior surgeries and hospitalizations for medical illnesses:

- removal of right lobe of thyroid
- c-section
- infertility treatments

Do you have any allergies to food or medications? If so, please list below & the type(s) of reaction (ie: hives, tongue swelling, etc.).

n/a