

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 6/7/16 Are you an AUM student? YES ☐ NO ☒ Student ID # N/A

Name: Leigh Anne Fagin

Social Security Number: 453-49-9526 Birth Date: 12/01/79

Local Phone Number: 512-680-8165 Alternate Number: N/A

Local Address: 3444 Wellington Rd Box Number: _____

City: Montgomery State: AL Zip Code: 36108

Permanent Address: N/A

City: N/A State: N/A Zip Code: N/A

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

Sex (Please Circle): Male ☐ Female ☒

Primary Physician: Nina Hubbard, FNP City: Montgomery Phone #: 334-286-2390

Patient's Employer: Baptist Medical Center South Work #: 334-744-9682

Parent's or Spouse's Name (Circle which) Charles Thomas Phone #: 512-680-8165
828-2252

Parent's or Spouse's Employer: Maxwell AFB Work #: N/A

Emergency Contact: Charles Thomas Relationship: husband Phone #: 512-828-2252

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 _____ Name on Card _____

Policy Number _____ Group Number _____

Insurance Company Address _____

AUM STUDENT HEALTH CENTER
CONSENT FOR SERVICES FORM

Patient Name Leigh Anne Fagin Date of Birth 6/7/16

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.

Leigh Anne Fagin
Signature of Patient

6/7/16
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 7th day of June 20 16.

Print Patient Name Leigh Anne Fagin

Signature [Signature]

Relationship to Patient patient

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

Name: Leigh Anne Fagin Date of Birth: 12/1/79

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 Charles Thomas

☐ 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: 512-680-8165

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: Leigh Anne Fagin Date: 6/7/16

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE 6/7/16 TIME: 230 PT. HISTORY REVIEWED / UPDATED / /

PATIENT NAME: Leigh Ann Fagin DOB: AGE:

PRESENT COMPLAINT: Pt needing typhoid vaccine prior to traveling on Friday
to Morocco and Spain. Understands she should have had
the injection earlier, RN

MEDICATIONS:						LMP:
Temp	Pulse	Resp	B/P	HT	WT	Allergies
						<u>shell fish</u>

INITIAL VISIT						RETURN VISIT
Skin						
Sinuses						
Ears						
Eyes						
Nose						
Throat						
Neck/Back						
Heart						
Lungs						
Abdomen						
GU/GI						
Extremities						

DIAGNOSIS:	TESTS	RESULTS

PLAN:

CALL BACK:

PRACTITIONER SIGNATURE: _____ STAFF SIGNATURE: _____

AUDIT DATE: _____ COMMENTS: _____

PHYSICIAN SIGNATURE: _____

UM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 6/7/16 Name Leigh Anne Fagin

1. What is the reason for your visit today Typhoid shot
2. List allergies you have to medicines, foods or iodine: crustaceans
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): tylenol extra strength
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 X
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? Morocco & Spain
8. How long is your trip? Months 0 Days 10
9. When are you leaving on your trip? 6/10/16

FOR FEMALES ONLY

- A. Date of your last period? 5/22/16 Have you had a hysterectomy? YES _____ NO X
- B. Are you currently pregnant? YES _____ NO X
What is your due date? N/A
- C. Do you plan to become pregnant in the next 3 months? YES _____ NO maybe?
- D. Are you breastfeeding? YES _____ NO X

Patient name:

Leigh Anne Taggin

Date of birth:

12/01/79
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Adults

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

Form completed by:

Leigh Anne Taggin

Date:

6/7/12

Form reviewed by:

[Signature]

Date:

6/7/16

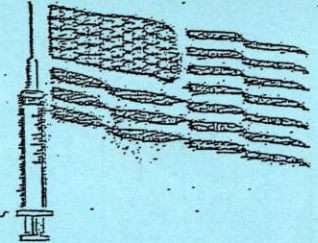
Did you bring your immunization record card with you? yes ☐ no ☒

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Protect Our Future!



Name: Leigh Ann Fagin

Date of birth: 12/01/79 Record # _____

Allergies: Shellfish Reactions: _____

History of Chickenpox? YES or NO If yes, date if known: _____

Immunize!

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Tdap					Tdap					0.5cc		IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B (booster if needed)					Hep B							IM	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	
Hepatitis A					Hep A							IM	
Hepatitis A					Hep A							IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
MCV4					Mening							IM	
MPSV4					Mening							SQ	

* Manufacturers: M = Merck; S = Sanofi Pasteur; W = Wyeth; G = GlaxoSmithKline

** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid

*** VIS Language given, if not English: _____

***Provider Information

[illegible]

Tuberculin Test

[illegible]

Titer Test Results for Non Susceptibility (IgM)

Date			Disease	Results		Notes
Mo	Day	Yr		Neg	Pos	

[illegible]