



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: 3/7/23 Student Number: 500 217 494 Birthdate: 3/19/1997

Last Name: Phillips First Name: Richard Preferred: _____

Phone Number: 334-546-0936 Email(AUM preferred): rphill10@aum.edu

Local Home Address: 1154 S Lawrence Street Box or APT#: _____

City: Montgomery State: AL Country: USA Zip Code: 36104

Permanent/ Home Address: 1154 S Lawrence Street APT#: _____

City: Montgomery State: AL Zip Code: 36104

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 ☐ Other: _____

Primary Physician: _____ City: _____ State: _____ Phone Number: _____

Patient's Employer: _____ Work Phone Number: _____

Emergency Contact: Sarah Phillips Relationship: Sibling Phone Number: 334-296-5310

Emergency Contact: _____ Relationship: _____ Phone Number: _____

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: Blue Cross Blue Shield-AL Policy or Contract Number: QAU829186718

Group number: 37655 Policy Holder Name: Richard Phillips

Relationship to Policy Holder: Self Policy Holder Date of Birth: 3/19/1997

Insurance Company's Address: _____

Secondary Insurance Company: _____ Policy or Contract Number: _____

Group number: _____ Policy Holder Name: _____

Relationship to policy holder: _____ 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: Richard Phillips Date: 03/07/2023
Print Patient's Name: Richard Phillips
Relationship to Patient (if you are the patient, write "self"): self

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

Name: Richard Phillips Date of Birth 03/19/1997

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: _____ Phone: _____ Relationship: _____

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: (334)-546-0936

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: Richard Phillips

Date: 03/07/23



Confidential Medical History Form

Name: Richard Phillips

DOB: 03/19/1997

Have you EVER had any of the following?

HEENT: ☒ Sinus Infections ☒ Strep ☐ Mono ☒ Seasonal Allergies ☐ Hearing loss Respiratory: ☐ Pneumonia ☒ 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 ☐ Skin cancer	☒ No significant health problems Surgeries: ☐ Tonsils & Adenoids ☐ Hysterectomy ☐ Appendectomy ☐ Cholecystectomy ☒ Other: <u>Prefer not to say</u> ☐ _____ ☐ _____ ☐ _____ ☐ _____
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Family History						
	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes	✓				✓	
Hypertension					✓	
Heart Disease						
Stroke						
High Cholesterol	✓					
Thyroid problems						
Cancer (List type)					✓ Can't remember	
Depression						
Alcoholism						

Confidential Medical History Form