

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT)

Date: 05/06/15 Are you an AUM student? ☒ YES ☐ NO Student ID # 500290170

Name: Salem Burgaid

Social Security Number: / Birth Date 01/26/85

Local Phone Number: / Alternate Number: /

Local Address: 9009 Black cherry TR Box Number /

City: pike Road State: Alabama Zip Code: 36064

Permanent Address: Benghazi - Libya - on the Airport Road

City: Benghazi State: / Zip Code: /

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

Sex (Please Circle): ☒ Male ☐ Female

Primary Physician: N/A City: N/A Phone #: N/A

Patient's Employer: / Work #: /

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

Parent's or Spouse's Employer: / Work #: /

Emergency Contact: / Relationship: / Phone #: /

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 Salem Burgaid Date of Birth 01/26/85

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.

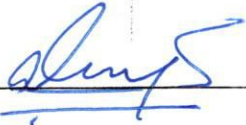
I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and 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.

Signature of Patient



Date of Signature

05/06/15

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 05 day of 06 2015.

Print Patient Name Salem Burgaid

Signature [Signature]

Relationship to Patient _____

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

Name: Salem Burgaid Date of Birth: 01/26/85

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) /

☐ 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: 334 462 1091

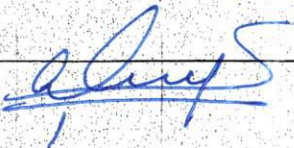
If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) work days between (time) 10:00-14:00

Signed:  Date: 06/05/15

AUM NURSING CARE CENTER

ADOLESCENT/ADULT HEALTH HISTORY

Date

06/05/15

Name

Salem Burgaid

1. What is the reason for your visit today? TP
2. Is there anything about you and your health that we need to know? N/A
3. List medicine, drugs, or food you are allergic to: No allergic
4. List any medicines or drugs you take: N/A No medicine or drug

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
stroke

diabetes/sugar
blood problem or disease
cancer

tuberculosis
birth defects
mental retardation

nerve or mental problems
asthma
died before age 50
other "family" disease

6. Have you ever been in the hospital? No Why? _____
7. Have you ever had surgery? No Why? _____
8. Have you ever had a serious accident? No
9. Have you had serious or recent problems with:

ears or throat	<u>NO</u> YES	cough	<u>NO</u> YES	kidneys	<u>NO</u> YES	gallbladder	<u>NO</u> YES
allergies	<u>NO</u> YES	thyroid	<u>NO</u> YES	weight loss	<u>NO</u> YES	liver	<u>NO</u> YES
lung infections	<u>NO</u> YES	skin problems	<u>NO</u> YES	ulcers	<u>NO</u> YES	depression	<u>NO</u> YES
						headaches	<u>NO</u> YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES
- If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?
- How much smokeless tobacco do you use a day? _____
13. How often do you drink beer, wine, wine coolers, or liquor?
- Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
- If you drink beer, wine, wine coolers, or liquor, do you have:
- (less) (more) than 5 drinks a day?

14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
15. Have you ever used I.V. drugs? NO YES
16. Have you ever had a blood transfusion? NO YES
17. Do you have any tattoos? NO YES
18. Have you ever been treated for a venereal disease? NO YES
19. Have you had more than one sex partner in the past 5 years? NO YES
20. Have you ever had sex with a member of your own sex? NO YES
21. Have you had or been around anyone with hepatitis? NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? _____ Date of your last period? _____
- How often do you have your periods? _____ Are they regular? _____
- How many days do they last? _____
- Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
- Do you check them regularly? YES NO
- C. How many times have you ever been pregnant? _____ How many children are living? _____
- Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
- Were any of your children premature? NO YES
- How old were you when your first child was born? _____
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES;
- diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES