



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: 6/1/2022 Student Number: 500340113 Birthdate: 03/30/1997

Last Name: Wessinger First Name: Gabriella Preferred: Gabi

Phone Number: (206) 216-1333 Email: gmccneely@aum.edu

Local Mailing Address: 214 Spring Hollow Dr Box or APT#: _____

City: Deatsville State: AL Country: USA Zip Code: 36022

Permanent/ Home Address: same as above APT#: _____

City: _____ State: _____ Zip Code: _____

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

Primary Physician: Dr. Russell Beatty City: Birmingham State: AL Phone Number: (206) 802-2000

Patient's Employer: Auburn University at Montgomery Work Phone Number: (334) 244-3716

Emergency Contact: Nicholas Wessinger Relationship: Spouse Phone Number: (334) 690-8558

Emergency Contact: Shasta Lunsford Relationship: Mother Phone Number: (334) 892-3385

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: AAU830019890

Group number: 37666 Name on Insurance Card: Gabriella D Wessinger

Relationship: Self Policy Holder Date of Birth: 03/30/1997

Insurance Company's Address: 460 Riverchase Parkway East Birmingham, AL 35244

Secondary Insurance Company: United Healthcare Policy or Contract Number: 921315612

Group number: 23000 Name on Insurance Card: B McNeely

Relationship: Father Policy Holder Date of Birth: 12/16/76

Insurance Company's Address: P.O. Box 30985, Salt Lake City, UT 84130-0985

Tertiary: All Savers P#: C06949066 Group: 908808 Name: Daniel Lunsford
Rel: Step-Father DOB: 01/11/72 P.O. Box 31375 Salt Lake City, UT 84131-0375

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 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: Gabriella Wessinger Date: 6 / 1 / 22
Print Patient's Name: Gabriella Wessinger
Relationship to Patient (if you are the patient, write "self"): self

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

Name: Gabriella Wessinger Date of Birth 03/30/97

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: (206) - 216 - 1333

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 ☒ Any Day
☐ Morning ☐ Early Afternoon ☐ Late Afternoon ☒ Anytime

Signature: Gabriella Wessinger

Date: 6/1/22



Confidential Medical History Form

Name: Gabriella Wessinger

DOB: 3/30/97

Have you EVER had any of the following?

HEENT: <u>Sinus Infections</u> <u>Strep</u> <u>Mono</u> X <u>Seasonal Allergies</u> Hearing loss Respiratory: <u>Pneumonia</u> <u>Bronchitis</u> Asthma COPD Cardiac: Hypertension High cholesterol Heart disease Heart murmur Hematology: <u>Anemia</u> Blood clots Sickle Cell Disease/Trait Cancer: _____	GI: <u>Irritable Bowel Syndrome</u> Ulcerative Colitis Crohn's disease Diverticulitis GERD/Reflux GU: <u>UTI</u> Kidney Stones Endometriosis Gonorrhea Chlamydia <u>Herpes</u> HPV Endocrine: Diabetes Hypothyroidism Grave's disease PCOS Other: _____ _____	Psych: <u>ADHD/ADD</u> <u>Anxiety</u> <u>Depression</u> 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: _____ _____ _____ _____
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	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes					X	
Hypertension	X				X	
Heart Disease					X	
Stroke						
High Cholesterol	X				X	
Thyroid problems						
Cancer (List type)						
Depression						
Alcoholism						

auto
immune
disease



Confidential Medical History Form

- ☐ Smoke if so, how many packs per day? _____ How many years? _____
- ☒ Alcohol if so, how much and how often? not much and not often - pregnancy + breastfeeding
- ☐ Drugs if so, how much and how often? What type? _____
- ☐ Living arrangements:
- ☐ On Campus w/ Roommates ☐ On Campus without Roommates
- ☐ Off Campus w/ Roommates ☐ Off Campus w/ Parents ☒ Off campus w/o Roommates

Over the past two weeks, have you often been bothered by:

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

Sexual Orientation?

Heterosexual (straight)

Gay or Lesbian

Bisexual

Other: _____

List current medications, including birth control, over the counter meds, vitamins, etc. (include dosage and frequency).

Please list allergies and reactions if known

latex

- ☐ Walmart Atlanta Hwy
- ☐ Walmart Chantilly
- ☐ Walgreens Atlanta Hwy
- ☐ CVS Atlanta Hwy
- ☐ Publix Taylor Junction
- ☐ Adams Copperfield

Other: CVS Pharmacy Millbrook, AL