



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: Sept/27/2022 Student Number: 500410631 Birthdate: 19/Feb/1999
Last Name: PALAGANI First Name: RAJESH Preferred: RAJESH
Phone Number: 334-840 8044 Email: rpalagan@aum.edu
Local Mailing Address: Taylor crossing Dr Box or APT#: 7000 Apt C
City: Montgomery State: Alabama Country: USA Zip Code: 36117
Permanent/ Home Address: G. Konduru Mandal, Koduru Village APT#: Library Street
City: Koduru Village State: Andhra Pradesh Zip Code: 5283521230
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: _____ City: _____ State: _____ Phone Number: _____
Patient's Employer: _____ Work Phone Number: _____
Emergency Contact: _____ Relationship: _____ Phone Number: _____
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: Care Health Insurance Policy or Contract Number: H4 43271726
Group number: 14309122 Name on Insurance Card: Mr. Palagani Rajesh
Relationship: self Policy Holder Date of Birth: 19-Feb-1999
Insurance Company's Address: Regd. Office 5th floor, 19 Chawla House, Nehru Place, New Delhi
Secondary Insurance Company: _____ Policy or Contract Number: 1800-102-6655
Group number: 14309122 Name on Insurance Card: Mr. Palagani Rajesh
Relationship: self Policy Holder Date of Birth: 19-Feb-1999 New Delhi
Insurance Company's Address: Regd. Office 5th floor, 19 Chawla House, Nehru Place

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

Name: RAJESH · PALAGANI Date of Birth 19 / Feb / 1999 .

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: TALAM SANKAR Phone: +1 - 402 - 913 - 4353 Relationship: cousin .

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) - 840 - 8044 .

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: P. Rajesh .

Date: 27 / sept / 2022



Confidential Medical History Form

Name: RAJESH PALAGANI

DOB: 19-Feb-1999

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: _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____
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Family History						
	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes						
Hypertension						
Heart Disease						
Stroke						
High Cholesterol						
Thyroid problems						
Cancer (List type)						
Depression						
Alcoholism						

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

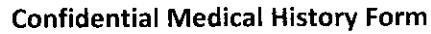
I am responsible for all bills incurred at the Warhawk Health Services. Payment is due at the time that services are rendered unless prior arrangements have been made.

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: P. Rajesh Date: 27/ sept/ 2022

Print Patient's Name: P. Rajesh

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



☐ Smoke if so, how many packs per day? _____ How many years? _____

☒ Alcohol if so, how much and how often? weekly once

☐ Drugs if so, how much and how often? What type? _____

☐ On Campus w/ Roommates ☐ On Campus without Roommates
☒ Off Campus w/ Roommates ☐ Off Campus w/ Parents ☐ Off campus w/o Roommates

☐ Heterosexual (straight)
☐ Gay or Lesbian
☐ Bisexual
☐ Other: NO

☒ Walmart Atlanta Hwy
☐ Walmart Chantilly
☐ Walgreens Atlanta Hwy
☐ CVS Atlanta Hwy
☐ Publix Taylor Junction
☐ Adams Copperfield
 Other: _____