



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: 9-22-22 Student Number: SOO/23515 Birthdate: 1-15-95  
Last Name: Farmer First Name: Tyra Preferred: \_\_\_\_\_  
Phone Number: 334-273-5759 Email: ~~Tyra22~~ Tyra22fs@hotmail.com  
Local Mailing Address: 8230 Parkview CT Box or APT#: \_\_\_\_\_  
City: Montgomery State: AL Country: Mont Zip Code: 36117  
Permanent/ Home Address: 8230 Parkview CT APT#: \_\_\_\_\_  
City: Montgomery State: AL Zip Code: 36117  
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: N.A. 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: Alabama Medicaid Policy or Contract Number: 5300016017331  
Group number: \_\_\_\_\_ Name on Insurance Card: Tyra Farmer  
Relationship: Self Policy Holder Date of Birth: 1-15-1995  
Insurance Company's Address: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_ Policy or Contract Number: \_\_\_\_\_  
Group number: \_\_\_\_\_ Name on Insurance Card: \_\_\_\_\_  
Relationship: \_\_\_\_\_ 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: Tyra T. Farmer. Date: 9 / 22 / 22  
Print Patient's Name: Tyra T. Farmer  
Relationship to Patient (if you are the patient, write "self"): Self

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

Name: Tyra Farmer Date of Birth 1/15/95

**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: (214)-773-5259

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: Tyra Farmer

Date: 9/12/22



# Confidential Medical History Form

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Have you EVER had any of the following?

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>HEENT:</b></p> <p><input type="checkbox"/> Sinus Infections</p> <p><input type="checkbox"/> Strep</p> <p><input type="checkbox"/> Mono</p> <p><input type="checkbox"/> Seasonal Allergies</p> <p><input type="checkbox"/> Hearing loss</p> <p><b>Respiratory:</b></p> <p><input checked="" type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> COPD</p> <p><b>Cardiac:</b></p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Heart murmur</p> <p><b>Hematology:</b></p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Blood clots</p> <p><input type="checkbox"/> Sickle Cell Disease/Trait</p> <p><input type="checkbox"/> Cancer:</p> <p><input type="checkbox"/> _____</p> | <p><b>GI:</b></p> <p><input type="checkbox"/> Irritable Bowel Syndrome</p> <p><input type="checkbox"/> Ulcerative Colitis</p> <p><input type="checkbox"/> Crohn's disease</p> <p><input type="checkbox"/> Diverticulitis</p> <p><input type="checkbox"/> GERD/Reflux</p> <p><b>GU:</b></p> <p><input checked="" type="checkbox"/> UTI</p> <p><input type="checkbox"/> Kidney Stones</p> <p><input type="checkbox"/> Endometriosis</p> <p><input checked="" type="checkbox"/> Gonorrhea</p> <p><input checked="" type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> HPV</p> <p><b>Endocrine:</b></p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Hypothyroidism</p> <p><input type="checkbox"/> Grave's disease</p> <p><input type="checkbox"/> PCOS</p> <p><b>Other:</b></p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> | <p><b>Psych:</b></p> <p><input type="checkbox"/> ADHD/ADD</p> <p><input checked="" type="checkbox"/> Anxiety</p> <p><input checked="" type="checkbox"/> Depression</p> <p><input type="checkbox"/> Bipolar</p> <p><input type="checkbox"/> Schizophrenia</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Bulimia</p> <p><b>Neurology:</b></p> <p><input checked="" type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><b>Infectious Disease:</b></p> <p><input type="checkbox"/> HIV/AIDS</p> <p><input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> Hepatitis</p> <p><b>Integumentary:</b></p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Skin cancer</p> | <p><input type="checkbox"/> No significant health problems</p> <p><b>Surgeries:</b></p> <p><input type="checkbox"/> Tonsils &amp; Adenoids</p> <p><input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> Appendectomy</p> <p><input type="checkbox"/> Cholecystectomy</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> |
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| Family History     |                                     |                                     |         |                                     |                                     |       |
|--------------------|-------------------------------------|-------------------------------------|---------|-------------------------------------|-------------------------------------|-------|
|                    | Father                              | Mother                              | Brother | Sister                              | Grandparent                         | Other |
| Diabetes           |                                     |                                     |         |                                     | <input checked="" type="checkbox"/> |       |
| Hypertension       |                                     | <input checked="" type="checkbox"/> |         |                                     |                                     |       |
| Heart Disease      |                                     | <input checked="" type="checkbox"/> |         |                                     |                                     |       |
| Stroke             |                                     |                                     |         |                                     |                                     |       |
| High Cholesterol   |                                     |                                     |         |                                     |                                     |       |
| Thyroid problems   |                                     |                                     |         |                                     |                                     |       |
| Cancer (List type) |                                     | Breast                              |         |                                     |                                     |       |
| Depression         |                                     |                                     |         | <input checked="" type="checkbox"/> |                                     |       |
| Alcoholism         | <input checked="" type="checkbox"/> |                                     |         |                                     | <input checked="" type="checkbox"/> |       |

# Confidential Medical History Form