

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 4.3.2018 Are you an AUM Student? Yes ☒ No ☐ S-Number: _____

Name: Jennifer French Birthdate: 8.13.1975

Main Phone Number: 334.322.2795 Alternate Phone Number: _____

Local Mailing Address: 156 Payne Rd Box or APT #: _____

City: Montgomery State: AL Zip Code: 36116

Permanent/Home Address: same ↑ Box or APT #: _____

City: _____ State: _____ Zip Code: _____

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

Sex (Please Circle): Male ☐ Female ☒ Gender: Male Female

Primary Physician: Dr Abt City: Montgomery Phone #: 286.2390

Patient's Employer: Trinity School Work Phone #: 213-2100

Parent's or Spouse's Name (Circle which): Wilford S French III Phone #: 334.322.2792

Parent's or Spouse's Employer: Mont. Radiology Phone #: _____

Emergency Contact: Stan French Relationship: husband Phone #: 322.2792

How did you hear about the clinic (Circle which): Friend ☒ Faculty/Staff ☐ Orientation ☐ Other: _____

INSURANCE INFORMATION

Do you have health insurance? X YES ☒ NO ☐

If yes, please give your card to the front desk in order for a copy to be made for your chart.

Insurance Company: BCBS Name on Card: Wilford S French III

Policy or Contract Number: PPA868141025 Group Number: 37338

Insurance Company's Address: 450 Riverchase Pkwy East
Birmingham, AL 35244

AUM STUDENT HEALTH CENTER

CONSENT FOR SERVICES FORM

Patient Name: Jennifer French Date of Birth: 08/13/75
Day Month Year

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 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.

Jennifer French
Signature of Patient

04/03/18
Day Month Year
Date of Signature

Signature of Legal Representative (if patient is unable to sign)

Relationship to Patient

Name: SEMMER FRENCH Date of Birth / /

☒ Spouse: Wilford S French III
☒ Child(ren): Lauren French, Hayley French,
Morgan French, Luke French
☒ Other: Physicians
☐ Information is not to be released to anyone.

Date: 04 / 03 / 18

AUM Student Health Services

PATIENT HIPPAA 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 (HIPPA). 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 HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. 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.

Signed this 3rd day of April 2018.
(day) (month) (last two digits of the year)

Print Patient's Name: Jennifer French

Signature: Jennifer French

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

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 4/2/2018 Name Jennifer French

1. What is the reason for your visit today International Vaccines

2. List allergies you have to medicines, foods or iodine: celcor

3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): None

4. Have you had any of the following: (circle if this applies to you):

Heart disease _____

Kidney disease _____

Stomach/Gastrointestinal disease _____

Diabetes/sugar _____

5. Are you immunocompromised? (Is there a problem with your immune system) Yes _____ No X

Thymus disorder (Myasthenia gravis, thymoma, thymectomy) _____

Spleen removed _____

Transplant recipient _____

Cirrhosis of the liver _____

Cancer _____

HIV _____

6. How often do you drink beer, wine, wine cooler, or liquor? (Please circle)

Never / Rarely 1-2 times a week / 3-4 times a week / 5 or more times a week

7. Where are you going on your trip? South Africa

8. How long is your trip? Months _____ Days 7

9. When are you leaving on your trip? April 17th - 24th

FOR FEMALES ONLY

A. Date of your last period? 3/9/18 Have you had a hysterectomy? YES _____ NO X

B. Are you currently pregnant? YES _____ NO X

What is your due date? _____

C. Do you plan to become pregnant in the next 3 months? YES _____ NO X

D. Are you breastfeeding? YES _____ NO X

AUBURN MONTGOMERY

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Name Jenny French Date 4/3/18

Address _____

R

Malarone 250/100mg

Disp: 15

Sig: Take one pill a day. Begin 2 days before departure, continue through stay and for 7 days after return.

R. Stewart, M.D. or C.R.N.P.
Product Selection Permitted

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written

M.D. or C.R.N.P.

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Rx: 0703

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Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Name Wilford French III Date 4/3/18

Address _____

R

Malarone 250/100mg

Disp: 15

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