

# AUM STUDENT HEALTH CENTER

## PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 11/04/2018 Are you an AUM Student? ☒ Yes ☐ No S-Number: 500360094

Name: Santiago Ceiquera Molano Birthdate: 26 Junio

Main Phone Number: 205 223 8715 Alternate Phone Number: \_\_\_\_\_

Local Mailing Address: \_\_\_\_\_ Box or APT #: \_\_\_\_\_

City: Montgomery State: Alabama Zip Code: \_\_\_\_\_

Permanent/Home Address: 4900 Plaza Dr Montgomery Alabama Box or APT #: APT 51

City: Montgomery State: Alabama Zip Code: 36176

Marital Status (Please Circle): Single Married Divorced Widowed Other: \_\_\_\_\_

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

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

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

Parent's or Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact: Cristian Marquez Relationship: Cousin Phone #: 205 905 5342

How did you hear about the clinic (Circle which): Friend Faculty/Staff Orientation Other: \_\_\_\_\_

## 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.*

Insurance Company: \_\_\_\_\_ Name on Card: \_\_\_\_\_

Policy or Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

# AUM STUDENT HEALTH CENTER

## CONSENT FOR SERVICES FORM

Patient Name: Santiago Cervera Molano Date of Birth: 26 / 06 / 1999  
Day Month Year

### General Consent for Treatment

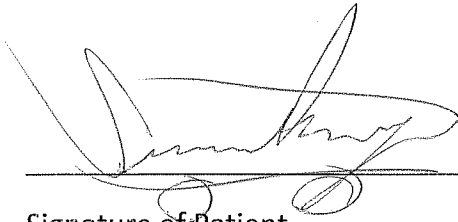
I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

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.

  
\_\_\_\_\_  
Signature of Patient

26 / 06 / 1999  
Day Month Year  
Date of Signature

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

\_\_\_\_\_  
Relationship to Patient

*AUM Student Health Services*  
*Medical Information Release Form*  
*(HIPPA Release Form)*

Name: Santiago Cesquera Molano Date of Birth 26 / 06 / 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:

☐ 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: (205) - 2238-715

If unable to reach me:

☒ you may leave me a detailed message

☐ please leave a message asking me to return your call

☐ other: \_\_\_\_\_

The best time to reach me is (day or days) from monday to Thursday between \_\_\_\_\_ and \_\_\_\_\_ times.

Signed: \_\_\_\_\_

Date: 11 / 04 / 2018

# 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 Wednesday day of April 2018.  
(day) (month) (last two digits of the year)

Print Patient's Name: Santiago Cerquera Molano

Signature: 

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

NAME: Santiago Cerquera Molano Date: 11 April 2018

## AUM Student Health Services Comprehensive Health History Form

**Medical History:** Do you have, or have you ever had any of the following? (check all that apply)

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Cardiovascular</b><br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Congestive Heart Failure<br><input type="checkbox"/> Atrial Fibrillation<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                          | <b>Gastrointestinal</b><br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Pancreatitis<br><input type="checkbox"/> Irritable Bowel<br><input type="checkbox"/> Colitis <input type="checkbox"/> Crohn's<br><input checked="" type="checkbox"/> Reflux                                                                                                    | <b>Respiratory</b><br><input checked="" type="checkbox"/> Asthma<br><input type="checkbox"/> COPD / Emphysema<br><input type="checkbox"/> TB (Tuberculosis)                                                                                                                                                                                      | <b>Immunologic / Viral</b><br><input type="checkbox"/> HIV / AIDS<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> Epstein-Barr                                                                                                      | <b>Endocrine</b><br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Thyroid (Hyper/Hypo)<br><b>Musculoskeletal</b><br><input type="checkbox"/> Arthritis                                                                                                                                                                      |
| <b>Neurologic</b><br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Alzheimer's / Dementia<br><input type="checkbox"/> Seizure Disorder<br><input checked="" type="checkbox"/> Headaches <input type="checkbox"/> Migraines<br><input type="checkbox"/> Sleep Apnea<br><input type="checkbox"/> Fibromyalgia<br><input type="checkbox"/> Insomnia (Can't Sleep) | <b>Kidney &amp; Urologic</b><br><input type="checkbox"/> Kidney Stones<br><input type="checkbox"/> Enlarged Prostate<br><input type="checkbox"/> Urinary Tract Infections<br><b>Liver</b><br><input type="checkbox"/> Gallstones<br><input type="checkbox"/> Cirrhosis<br>Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <b>Reproductive</b><br><input type="checkbox"/> Hysterectomy<br><input type="checkbox"/> Contraceptives Used:<br>Menstrual Cycle:<br><input type="checkbox"/> Regular <input type="checkbox"/> Irregular<br><input type="checkbox"/> Genital Disease(s)<br><input type="checkbox"/> Infertility<br><input type="checkbox"/> Erectile Dysfunction | <b>Ear/Nose/Throat/Eye</b><br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Cataract<br><input type="checkbox"/> Chronic Sinus Infection<br><input type="checkbox"/> Upper Airway Infections<br><input type="checkbox"/> Dizziness | <b>Other</b><br><input type="checkbox"/> Cancer (explain):<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Sickle Cell<br><input type="checkbox"/> On Anticoagulants<br><input type="checkbox"/> Chronic Pain (explain):<br><input type="checkbox"/> Skin Conditions (explain): |

**Review of Systems:** (check all SYMPTOMS that apply)

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Systemic</b><br>Weight: <input type="checkbox"/> gain <input type="checkbox"/> loss<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Chills<br><input type="checkbox"/> Night Sweats<br><input type="checkbox"/> Pain                                                                                                                                                                                                                                                                                                                                                            | <b>Gastrointestinal</b><br>Appetite: <input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor<br><input type="checkbox"/> Difficulty Swallowing<br><input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting<br><input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation<br><input type="checkbox"/> Heartburn <input type="checkbox"/> Rectal Bleeding<br><input type="checkbox"/> Abdominal Pain | <b>Cardiovascular</b><br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Palpitations<br>(irregular heartbeat)                                                                                                                                                     | <b>Skin</b><br><input type="checkbox"/> Dry Skin<br><input type="checkbox"/> Itchy Skin<br><input type="checkbox"/> Peeling Skin<br><input type="checkbox"/> Scaling Skin<br><input type="checkbox"/> Discolored Skin<br><input type="checkbox"/> Rash(es) on Skin                                                                                                                                                                                                                                                                                   | <b>Endocrine</b><br><input type="checkbox"/> Excessive Thirst<br><input type="checkbox"/> Heat Intolerance<br><input type="checkbox"/> Cold Intolerance<br><input type="checkbox"/> Excessive Sweating<br><input type="checkbox"/> Feelings of Weakness                                                                                                      |
| <b>Neurologic / Head</b><br><input type="checkbox"/> Involuntary Movements<br><input type="checkbox"/> Speech Problems<br><input type="checkbox"/> Paralysis<br><input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting<br><input type="checkbox"/> Vertigo<br><input type="checkbox"/> Confusion<br><input type="checkbox"/> Memory Loss<br><input type="checkbox"/> Limb Weakness<br><input type="checkbox"/> Balance Problems<br><input type="checkbox"/> Tingling <input type="checkbox"/> Numbness<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Sinus Pain | <b>Genitourinary</b><br><input type="checkbox"/> Blood in Urine<br><input type="checkbox"/> Odor in Urine<br><input type="checkbox"/> Frequent Urination<br><input type="checkbox"/> Difficult Urination<br><input type="checkbox"/> Small Amount of Urine<br><input type="checkbox"/> Night Time Urination<br><input type="checkbox"/> Incontinent of Urine                                                                                               | <b>Pulmonary</b><br><input type="checkbox"/> Difficulty Breathing<br><input type="checkbox"/> Short of Breath<br><input type="checkbox"/> Dry Cough<br><input type="checkbox"/> Productive Cough<br><input type="checkbox"/> Cough with Blood<br><input type="checkbox"/> Wheezing | <b>Eye and Ears-Nose-Throat</b><br><input type="checkbox"/> Vision<br><input type="checkbox"/> Diplopia<br><input type="checkbox"/> Blurry Vision<br><input type="checkbox"/> Red Eyes<br><input type="checkbox"/> Hearing Loss<br><input type="checkbox"/> Tinnitus (ringing in ear)<br><input type="checkbox"/> Epistaxis (nose bleeds)<br><input type="checkbox"/> Nasal Itching<br><input type="checkbox"/> Sore Throat<br><input type="checkbox"/> Mouth Sores<br><input type="checkbox"/> Mouth Dryness<br><input type="checkbox"/> Runny Nose | <b>Musculoskeletal</b><br><input type="checkbox"/> Back Pain<br><input type="checkbox"/> Muscle Aches<br><input type="checkbox"/> Muscle Cramps<br><input type="checkbox"/> Joint Pain - localized<br><input type="checkbox"/> Joint Swelling - localized<br><input type="checkbox"/> Joint Stiffness - localized<br><input type="checkbox"/> Arthritis Pain |

**Please list all prior surgeries and hospitalizations for medical illnesses:**

**Do you have any allergies to food or medications? If so, please list below & the type(s) of reaction (ie: hives, tongue swelling, etc.).**