



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: 12/1/25 Student Number: _____ Birthdate: 6/16/1976
Last Name: Latchem First Name: Shelley Preferred: Robin
Phone Number: 931-206-4305 Email(AUM preferred): slatchem@aum.edu
Local Home Address: 1905 Seaton Park Box or APT#: _____
City: Montgomery State: AL Country: USA Zip Code: 36116
Permanent/ Home Address: 1905 Seaton Park APT#: _____
City: Montgomery Country: USA State: AL Zip Code: 36116
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 ☐ Other: _____
Primary Physician: Katie Carter, NP City: Montgomery State: AL Phone Number: 334-281-1191
Patient's Employer: AUM Work Phone Number: 334-394-5461
Emergency Contact Person: Peggy Latchem Relationship: mother Phone Number: 931-206-8037
Emergency Contact Person: Amanda Bell Relationship: sister Phone Number: 704-989-3317

INSURANCE INFORMATION

Do you have health insurance? ☒ Yes ☐ No

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

Primary Insurance Company: BCBS of AL Policy/Contract Number or Member ID: QAU818540143
Group number: 33503 Policy Holder Name: Shelley Robin Latchem
Relationship to Policy Holder: Self Policy Holder Date of Birth: 6/16/1976
Insurance Company's Address: 450 Riverchase Parkway East
Secondary Insurance Company: N/A Policy/Contract Number or Member ID: _____
Group number: _____ Policy Holder Name: _____
Relationship to policy holder: _____ 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 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: Shelley Robin Catcher Date: 12 / 1 / 25

Print Patient's Name: Shelley Robin Catcher

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

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

Name: Shelley Robin Latchem Date of Birth 6/16/1976

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: Peggy Latchem Phone: 931-206-8037 Relationship: Mother

Name: Amanda Bell Phone: 704-989-3317 Relationship: Sister

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: (931)-206-1305

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: Shelley Robin Latchem

Date: 12/1/25



Confidential Medical History Form

Name: Shelley Robin Latchum

DOB: 6/16/1976

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 <u>IDA</u> ☐ 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: <u>thyroidectomy</u> ☐ 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: _____ ☐ <u>thyroidectomy 2018</u> ☐ <u>liverectomy 2024</u> ☐ _____ ☐ _____
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Family History

	Father	Mother	Brother	Sister	Grandparent	Other
Diabetes					<u>great grand mother</u> ☒ maternal	
Hypertension		☒				
Heart Disease						
Stroke					<u>great grand mother</u> ☒ maternal	
High Cholesterol		☒				
Thyroid problems						
Cancer (List type)					<u>paternal</u> ☒ grandfather - liver	
Depression						
Alcoholism						



Confidential Medical History Form

Social History

- ☐ Smoke if so, how many packs per day? N/A How many years? N/A
- ☐ Alcohol if so, how much and how often? N/A
- ☐ Drugs if so, how much and how often? What type? N/A
- ☐ Living arrangements:
- ☐ On Campus w/ Roommates ☐ On Campus without Roommates
- ☐ Off Campus w/ Roommates ☐ Off Campus w/ Parents ☒ Off campus w/o Roommates

Depression Screening

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/Gender

Sexual Orientation?

- ☒ Heterosexual (straight)
- ☐ Gay or Lesbian
- ☐ Bisexual
- ☐ Other: _____
- ☐ Prefer not to answer

Medications

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

Levothyroxine 112mcg 1x daily

Clarith-D as needed

Allergies

Please list allergies and reactions if known. If no allergies, write none

Allergic to erythromycin

Pharmacy

- ☐ Walmart Atlanta Hwy
- ☐ Walmart Chantilly
- ☐ Walgreens Atlanta Hwy
- ☒ Publix Taylor Junction Cornerstone Pk 11x
- ☐ Adams Copperfield
- Other: _____