

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 4/27/18 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____
Name: Sandra K Thrasher Birthdate: 6/22/67
Main Phone Number: 334-322-1427 Alternate Phone Number: 334-260-3329
Local Mailing Address: 112 Long Branch drive Box or APT #: _____
City: Dadeville State: AL Zip Code: 36853
Permanent/Home Address: Same as above 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 Muhammad City: Montgomery Phone #: _____
Patient's Employer: GDI T Work Phone #: 334-260-3329
Parent's or Spouse's Name (Circle which): _____ Phone #: _____
Parent's or Spouse's Employer: _____ Phone #: _____
Emergency Contact: Raven Thrasher Relationship: Daughter Phone #: 334-
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: Blue Cross Blue Shield Name on Card: Sandra K Thrasher
Policy or Contract Number: GKD813278624 Group Number: 73695
Insurance Company's Address: 450 River Chase Parkway East
Birmingham, AL 35244

AUM STUDENT HEALTH CENTER

CONSENT FOR SERVICES FORM

Patient Name: Sandra K Thrasher Date of Birth: 6 / 22 / 87
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

____/____/____
Day Month Year
Date of Signature

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

Relationship to Patient

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 27th day of April 2018.
(day) (month) (last two digits of the year)

Print Patient's Name: Sandra K Thrasher

Signature: [Signature]

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

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

Name: Sandra Thrasher Date of Birth 6/22/67

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): Kara Thrasher

☐ 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: (334)-322-1427

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) any day between 6 am and 8 pm times.

Signed: [Signature]

Date: 8/27/18

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 4/27/18 Name Sandra K. Thrash

1. What is the reason for your visit today Hep A/B travel shots
2. List allergies you have to medicines, foods or iodine: N/A
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): lisopril blood pressure

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? Peru

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

9. When are you leaving on your trip? May 31, 2018

FOR FEMALES ONLY

- A. Date of your last period? 4/21/18 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