AUBURN UNIVERSITY PHARMACEUTICAL CARE CENTER
Patient Intake Form

Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**
Mailing Address **City/State/Zip:**	**Primary Phone Number:** **( )**	**Secondary Phone Number:** **( )**	
Email Address:	**Pharmacy Name/Phone Number:**	**Primary Physician:**	
Primary Insurance Contract Number:	**Group Number:**	**Subscriber Name/Date of Birth/Relationship to Patient:**	
Secondary Insurance Contract Number:	**Group Number:**	**Subscriber Name/Date of Birth/Relationship to Patient:**	
Emergency Contact:	**Relationship to Patient:**	**Phone Number:** **( )**	

Please list anyone that you give permission for us to discuss your personal health information with:

_____ _____ _____
Name **Relationship to Patient** **Phone Number**

_____ _____ _____
Name **Relationship to Patient** **Phone Number**

Preferred Methods of Communication
Check one or more of the following:

_____ Leave a message with detailed information to phone number listed in my record

_____ Leave a message with call back name and phone number only to phone number listed in my record

_____ Email correspondence to email listed in my record

_____ Mail correspondence to home address listed in my record

Signature: _____ **Date:** _____

AGREEMENTS AND AUTHORIZATIONS

Auburn University Clinical Health Services (CHS) operates three clinics: Auburn Pharmaceutical Care Center (AUPCC), State Employees' Insurance Board (SEIB) Healthcare Clinic, and Auburn University Health Care and Education Clinic (AUHEC). The following document will use "CHS clinics" as a collective term to represent the AUPCC, SEIB Healthcare Clinic and AUHEC.

CONSENT FOR SERVICE

I hereby consent to the services provided by the AU CHS clinics. I understand that these services may include limited physical assessment, lab testing, vaccinations, and non-invasive testing along with cognitive services. _____ (initial)

CONSENT TO OBTAIN MEDICATION HISTORY

I authorize the CHS clinics to utilize electronic means to obtain my medication history. SureScripts is the information exchange which allows the CHS clinics to communicate with participating pharmacies electronically to send prescriptions and obtain previously prescribed medications. This medication history may not be an all-inclusive list but can help our clinicians prescribe appropriate treatment and avoid potentially dangerous drug interactions. _____ (initial)

PRIVACY POLICY

I acknowledge having received the "Notice of Privacy Policies". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke my consent for release of my health care information in writing, except to the extent the CHS clinics have already made disclosures with my prior consent. _____ (initial)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purposes of diagnosis or treatment, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the CHS clinics. I authorize the release of any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the CHS clinics may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. _____ (initial)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT

I accept full responsibility for all charges for services rendered by the CHS clinics. I authorize my insurance carrier to release information regarding my coverage to the CHS clinics. I assign all benefits and authorize payment directly to the CHS clinics of any medical or government benefits due from my insurance, health plans, and/or government programs. I agree, in the event of non-payment or underpayment, to assume the costs of the difference, interest, collection, and/or legal action (if required). In the event that my insurance carrier does not accept this Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments from CHS clinics. _____ (initial)

WELLNESS PROGRAM (see below for applicable program notices)
I have read the Notice Regarding the Wellness Program, understand the policies and procedures set out in the Notice to protect the privacy and confidentiality of my personally identifiable health information, and agree that my personally identifiable health information contained on this Screening Form may be disclosed and/or used in the manner described in the Notice. I further acknowledge that I am participating in this Wellness Program voluntarily in order to identify whether I am at increased risk for certain medical conditions resulting from high blood pressure, obesity, high cholesterol, or diabetes.

(Notice applicable only for SEIB wellness program participant spouses) - I hereby acknowledge receipt of the Spousal Notice and Authorization for Wellness Program. I knowingly and voluntarily authorize the SEIB wellness program to collect the genetic information specifically described in the Notice and set out in the Screening Form below.

_____ _____

Patient or Authorized Person Signature **Date**

AU Notice **LGHIP Notice** **PEEHIP Notice** **SEIB Notice**




Medical History Update:

❑ Allergic Rhinitis (Hayfever)	❑ High blood Pressure
❑ Anemia or other blood problems	❑ Eye problems
❑ Anxiety or mental health issue	❑ Gout
❑ Asthma	❑ Headaches Type:
❑ Arthritis Type:	❑ Stroke
❑ Urinary Type:	❑ Sleep Apnea
❑ Cancer Type:	❑ Thyroid disorder
❑ Heartburn	❑ Heart disease
❑ Irritable Bowel or other gastrointestinal problem	❑ High cholesterol
❑ Pneumonia or respiratory problem	❑ Diabetes / High Blood Sugar
❑ Other:	

Surgical & Hospitalization History:

Year	Reason for surgery or hospital visits including emergency department visits

Family History:

Check all that may apply.

Disease State	Mother	Father	Sibling
Diabetes	❑	❑	❑
High Blood Pressure	❑	❑	❑
High Cholesterol	❑	❑	❑
Heart Disease	❑	❑	❑
Cancer	❑	❑	❑

Social History:

- **Tobacco:**
  - Do you currently or have you previously used any type of tobacco (cigars, cigarettes, vaping, chewing tobacco, snuff, etc.)? YES NO
  - At what age did you start? _____ What age did you stop? _____
  - How much did you or do you use per day on average?_____
- **Alcohol:**
  - Do you consume alcoholic beverages?_____
  - If yes, what type of alcohol do you drink?_____
  - How often do you drink?_____
- **Drugs:**
  - Do you use recreational drugs (marijuana, cocaine, etc.)? _____
  - If so, what type? _____

Allergies:

Please list additional allergies on the back of this page if needed.

Medication or other allergies	Type of reaction

Medication List:

Please list all prescription and over the counter medications. Continue list on the back of this page if needed.

Medication Name	Dose (milligrams, units, etc.)	When do you take it? (time of day)	When did you start taking this medication?	What is this medication for?