Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION **Marital Status:** Single Married Divorced Widowed **Sex:** Male Female

Name: _____ _____ _____
Last Name First Name Initial

Date of Birth: ____/____/____ Social Security #: ____-____-____

Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell Phone: (____) ____-____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Race: _____ Ethnicity: _____

PATIENT'S/RESPONSIBLE PARTY INFORMATION **Relationship to Patient:** Self Spouse Child Other: _____

Name: _____ _____ _____
Last Name First Name Initial

Date of Birth: ____/____/____ Social Security#: ____-____-____

Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell Phone: (____) ____-____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Race: _____ Ethnicity: _____

PHARMACY INFORMATION Name: _____ Telephone#: (____) ____-____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell Phone: (____) ____-____

DO YOU HAVE AN ADVANCE DIRECTIVE? [ ] YES [ ] NO

IF NOT, YOU MAY CONTACT A LAWYER TO HAVE ONE SET UP FOR YOU.

ATTENTION PATIENT

Due to a limited space for appointments, we ask that you please give us a call ahead of time to either cancel or re-schedule any of your appointments. Any patient that schedules and does not show up for their office visit will be charged a $15.00 fee for failure to appear to any of your doctor's appointment. After carefully reading the above statement, with my signature below, I am agreeing to this no-show policy.

Email: _____

Assignment of Benefits • Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to FAMILY CARE CLINIC, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

Toks Akinyeye, MD

1661 Rollingbrook Dr. Suite A
Baytown, TX 77521
Telephone: (281) 422 – 9967
Fax: (281) 422-1032

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
(Please Mail In Medical Records If More Then 10 Pages)

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE MY MEDICAL RECORDS TO BE RELEASED FROM:

Name of Doctor: _____

Address: _____

Telephone: _____ Fax: _____

REGARDING THE FOLLOWING INFORMATION FOR CONTINUITY OF CARE:

___Laboratory Results

___Radiology and Imaging Reports

___Other Tests (Please Specify): _____

___Entire Medical Records

___Other: _____

I understand that the information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV); or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS:

_____ _____

Signature of Patient or Qualified Personal Representative Date

Toks Akinyeye, MD

1661 Rollingbrook Dr. Suite A
Baytown, TX 77521
Telephone: (281) 422 – 9967
Fax: (281) 422 – 1032

I _____ give Dr. Toks Akinyeye MD permission to release all medical information to the following people: (Please select a password to issue to the following people upon calling the office. Each person will be asked to verify this password before information can be released) **PASSWORD:** _____

1. _____
2. _____
3. _____
4. _____

I understand that this form is effective immediately upon signing and is valid unless I make changes.

_____ _____

Patient Signature Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Toks Akinyeye, MD

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CONSENT TO MEDICAL TREATMENT

I, or authorized representative acting on behalf of the patient, or as a parent or legal guardian of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment by the physician, his assistants or his designees consider to be necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatments or examination at Family Care Clinic.

Signed: _____ Date: _____

Relationship, if other than patient: _____

Witness: _____ Date: _____