

# PATIENT REGISTRATION FORM

Name: \_\_\_\_\_  
Last First Initial

Address: \_\_\_\_\_  
Street City Zip

Home Ph.: \_\_\_\_\_ Wk. Ph.: \_\_\_\_\_ Cell: \_\_\_\_\_

Soc. Sec. Number: \_\_\_\_\_ Driver's Lic.: \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Marital Status: M S W D

Patient's Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring Dr.: \_\_\_\_\_ PCP: \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Insurance Information:

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Insurance is not a substitute for payment. Many companies have fixed allowances of percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not covered by insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Primary Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Group Name: \_\_\_\_\_ GP#: \_\_\_\_\_

-----  
I authorize the release of all medical information/records necessary to process my claims and that is pertinent to my medical care. I assign all medical benefits to Dr. Yomi Fayiga. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I agree to be financially responsible for all charges.  
I have read this information and understand the above.

Patient (Parent if minor) \_\_\_\_\_ Date: \_\_\_\_\_

ELLIS COUNTY SURGICAL ASSOCIATES

CONSENT FOR THE USE AND/OR DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION FOR TREATMENT, PAYMENT OF HEALTHCARE OPERATIONS

---

(Patient's Full Name)

---

(Patient's Address)

---

(Patient's Date of Birth and or SS#)

I understand that as part of my healthcare, Ellis County Surgical Associates originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, procedure codes, and treatment plans. I understand that this information serves as:

- A basis of care and treatment plan
- A means of communication among other health professionals who contribute to my care
- A source of information for applying diagnosis and procedure information to my bill
- A means by which a third party payer can verify that services billed were actually performed.

I understand and have been provided with a *Notice of Health Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the *Notice of Health Information Practices* prior to signing the consent. I understand that Ellis County Surgical Associates reserves the right to change their notice and practices and prior to implementation will mail a copy of any restrictions as to how my health information may be used or disclosed to carry out treatment or healthcare operations or obtain payment and the Ellis County Surgical Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Ellis County Surgical Associates has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

---

---

I consent to treatment and the use and disclosure of my health information for treatment, healthcare operations and payment as described in the *Notice of Health Information Practices*.

\_\_\_\_\_  
Signature of Patient or Legal Rep.

\_\_\_\_\_  
(Practice) Signature of Employee Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Notice or Version Effective Date

Accepted: \_\_\_\_\_

Denied: \_\_\_\_\_

\_\_\_\_\_  
Privacy/Security Officer

\_\_\_\_\_  
Date:

I hereby revoke/amend the consent given above as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

Address for revocation: \_\_\_\_\_  
Your revocation will be effective once it is received at the above address.

Accepted: \_\_\_\_\_

Denied: \_\_\_\_\_

\_\_\_\_\_  
Privacy/Security Officer

\_\_\_\_\_  
Date:

PATIENT AUTHORIZATION RELEASE OF  
PHI/IIHI BY TELEPHONE FOR BILLING PURPOSES

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

---

---

2. Please list the family members or significant others, if any, whom your bill may be discussed with:

---

---

3. Please print the address of where you would like your billing statements and or correspondence from our office to be sent if other than your home.

---

---

4. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, billing matters, or other health care information if other than you home phone number:

( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

5. Can confidential messages (i.e. Appointment reminders) be left on our home answering machine or voicemail? \_\_\_\_\_ yes    \_\_\_\_\_ no

6. If you do not have voicemail, can a confidential message be left at your place of employment? \_\_\_\_\_ yes    \_\_\_\_\_ no

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

PATIENT HISTORY  
YOMI J. FAYIGA, M.D.

Patient Name: \_\_\_\_\_

Chief Complaint/Reason for Visit: \_\_\_\_\_ Date: \_\_\_\_\_

-- HISTORY – PRESENT ILLNESS *Please give a brief description of your problem.*

Nature and duration: \_\_\_\_\_

When did it begin?: \_\_\_\_\_

Severity: \_\_\_\_\_

Possible Cause: \_\_\_\_\_

Remedies tried: \_\_\_\_\_

-- REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

-- PAST SURGERIES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

-- MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

-- ALLERGIES: \_\_\_\_\_

-- PHARMACY PREFERRED: \_\_\_\_\_

-- FAMILY MEDICAL HISTORY

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Sibling: \_\_\_\_\_

Sibling: \_\_\_\_\_

Children: \_\_\_\_\_

Children: \_\_\_\_\_

-- REVIEW OF SYSTEM: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

-- PERSONAL HISTORY

Tobacco: YES/NO

Alcohol: YES/NO

Drugs: : YES/NO

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: : \_\_\_\_\_ Date: \_\_\_\_\_