Patient Registration Form - Ifeanyi Obianyo, M.D

PATIENT INFORMATION

__Dr __Mr __Mrs. __Ms. __Jr. __Sr. __Other: _____

Patient's Name (Last) _____, (First) _____ (Middle) _____

Also Known As Name: (Last)_____, (First) _____

Marital Status: ____Married ____Single ____Divorced ____Widowed ____Legally Separated ___Other: _____

Social Security Number: _____-_____-_____ Female ____ Male ____ Date of Birth: _____/_____/_____

E-Mail Address: _____

Phone Numbers: Work _____ Day___ Evening ___ Home _____ Day___ Evening ___

Cellular _____ Day___ Evening ___ Other _____ Day ___ Evening ___

Address: _____

City, State, Zip (+4): _____

Employment Status: _____Employed _____Full-Time Student ____Part-Time Student _____Retired _____Self-Employed _____Unemployed

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone Number: _____

Emergency Contact Relationship to Patient: _____

Referring Providers / Persons Name: _____

RESPONSIBLE PARTY INFORMATION: ***(ONLY IF NOT THE PATIENT)***

__Dr __Mr __Mrs. __Ms. __Jr. __Sr. __Other: _____

Patient's Name (Last) _____, (First) _____ (Middle) _____

Also Known As Name: (Last)_____, (First) _____

Marital Status: ____Married ____Single ____Divorced ____Widowed ____Legally Separated ___Other: _____

Social Security Number: _____-_____-_____ Female ____ Male ____ Date of Birth: _____/_____/_____

E-Mail Address: _____

Phone Numbers: Work _____ Day___ Evening ___ Home _____ Day___ Evening ___

Cellular _____ Day___ Evening ___ Other _____ Day ___ Evening ___

Address: _____

City, State, Zip (+4): _____

Employment Status: _____Employed _____Full-Time Student ____Part-Time Student _____Retired _____Self-Employed _____Unemployed

Employer: _____ Occupation: _____

Relationship to Patient: _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature: _____ ***Date:*** _____

Finacial Agreement

Patient and/or guarantor are responsible for charges incurred. All payments are due at the time services are rendered. I understand all services and procedures are elective and not medically necessary. Our office will not file your health insurance for any services rendered. Our office is not your primary care and you must have a primary care physician for all my medical needs. If we are unable to obtain payment within reasonable amount of time (90 days) from the patient and/or guarantor, we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable. I, _____ **(*Please print clearly*)** have fully read and understand the above statement of payment policy. I authorize the physician to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____

Patient (or Responsible Party) Signature **Date**

_____ _____

Witness **Date**

Consent for Photograph Or Other Recording

I consent _____ ***(Patient/Representative Initials)*** to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., informational, educational, marketing (advertising), sales purpose). In addition to standard documentation of procedure, I understand that these photographs may appear on web sites, in printed materials, in presentations or exhibits, or in other forms of media, as determined by Ifeanyi O. Obianyo, MD. I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent _____ ***(Patient/Representative initials)*** to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities, advertising).

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____/_____/ _____