Fesss Family Health Care, LLC   Francis K. Attiogbe, MD
3039 Memorial Court, Las Cruces NM 88011
Phone 575-522-4145 fax 575-522-5236

PATIENT REGISTRATION

Last name	First name	Middle initial	Date

Address	City	State	Zip

Phone (Home)	Cell	email

Date of Birth	Social Security#	Sex □ Male □ Female	Status □ Single □ Married □ Other

Check all that apply □ employed □ Unemployed □ part-time Student □ Full time student

Emergency contact	Phone number	Relation

AUTHORIZATION FOR SECOND PERSON TO SEE MY CHART

Name and relationship to patient	Phone

CONSENT FOR TREATMENT

The undersigned does hereby request and give consent to Francis K. Attiogbe, MD and his medical personnel to administer such medications and perform such procedures as may be deemed necessary for the care and treatment of the undersigned patient. Initials:_________

ASSIGNMENT OF INSURANCE BENEFTIS

I hereby authorized direct payment of surgical/medical benefit for Francis K. Attiogbe, MD for services rendered by him in person or under supervision. I understand that I am financially responsible for any balance not covered by insurance, Medicare, Medicaid, Commercial, Self-pay initials:__________

CONSENT FOR TREATMENT

I hereby authorize Francis K. Attiogbe, MD to release any medical or incidental information that may be necessary for either medical care in processing applications for financial benefits by made on my behalf. Initials:__________

INSURANCE CONSENT

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request that payment of authorized benefits be made on my behalf. Initials:__________

□ check here if you are a self-pay □ Medicare □ Medicaid □ Commercial □ Other

PATIENT NAME (Print)____SIGNATURE:______________________

PARENT/GUARDIAN IF MINOR____ DATE:______________________

HEALTH QUESTIONNAIRE

Name	DOB	Date

Have you ever been diagnosed with or currently have any of the following conditions:

□Diabetes □Heart attack, stroke □Hepatitis □Other:________________
□Hypertension □Depression □Renal dysfunction □Cancer specify__________
□Asthma □Kidney disease □COPD ______________________
□Headaches □Thyroid problems □Circulation problems
□Heart problems □Osteoporosis □Chemical dependency (tobacco, drugs, alcohol)
□Anemia
□Seizures

For women: are you currently pregnant or think you might be pregnant? □ Yes □ No

Have recently experience this problems

Weight loss or gain: ____________________________
Nausea or vomiting: ____________________________
Do you have difficult hearing:____________________
Fever, chills, or swelling:_________________________
Numbness or tingling:____________________________
Weakness:______________________________________
Fatigue:____
Other:____

Please check what of those procedures have done in the last year : Preventive care

□Colonoscopy
□Mammogram
□A1c (Diabetic patients)
□Eye exam (Diabetic Patients)
□ Pneumonia vaccine
□ Flu vaccine
□ Shingles vaccine
□ Tetanus vaccine
□Osteoporosis Screening
□PSA (prostate) screening

Medication List

Allergies:_____________

Name	Dosage	Frequency
_________________________	__________________________________	_____________________________
_________________________	__________________________________	_____________________________
_________________________	__________________________________	_____________________________
_________________________	__________________________________	_____________________________
_________________________	__________________________________	_____________________________
_________________________	__________________________________	_____________________________
_________________________	__________________________________	_____________________________
_________________________	__________________________________	_____________________________

General Health Status

At the present time, would you say your health is:

□ Excellent □ Good □ Fair □ Poor

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected Health information. I understand that his information ca be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and may contact this organization at any time at the address listed above to obtain current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Name (print):____

Parent (if minor):____

Signature: ____

Date: ____

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COMMITMENT TO APPOINMENT POLICY

It is goal of Fesss Family Healthcare to provide efficient and effective outpatient care for all patients. To meet this goal we reserve time for each patient in our practice. An appointment writing in our schedule with your name on it is a bond of trust indicating that we will be here to serve you and you will be present for that appointment. Your signature below implies that we must have mutual respect for each others time.

A fee of $25.00 dollars. Will be charged for

- Missed appointment without notice
- Appointment that have not been canceled by patient at least 24 hrs. Before schedule time.

If you are more than 30 minutes late, your appointment will be canceled. Please call at least 30 minutes prior to your appointment if you know you are going to be late. We no longer accept walk –in appointments.

Name: ____ Date: _______________________________