C. TOBENNA OKEZIE, M.D.

PATIENT INFORMATION SHEET

NAME: _____ SS#_____

A MINOR, PARENT'S NAME: _____ DATE OF BIRTH: _____

STREET _____CITY/STATE_____ ZIP _____

TEL#: HOME _____ CELL #_____ BUSINESS # _____

MARITAL STATUS: S M W D SEX: M F

SPOUSE'S NAME: _____ SPOUSE EMPLOYER/ADDRESS _____

EMERGENCY CONTACT _____ TEL#: _____ RELATIONSHIP: _____

REFERRED BY: *PHYSICIAN* - DR. _____ *HMO BOOK / YELLOW PAGES / HOSPITAL*_____

FRIEND / RELATIVE: _____ *OTHER* _____

PATIENT EMPLOYER INFORMATION

OCCUPATION: _____

EMPLOYER NAME: _____TEL#: _____

EMPLOYER ADDRESS _____ CITY/STATE_____ ZIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. NAME: _____

POLICY #: _____ POLICY ID#:_____ RELATION: SELF/ SPOUSE/ CHILD

SECONDARY INSURANCE CO. NAME: _____

POLICY #: _____ GROUP #:_____

GENERAL MEDICAL INFORMATION

DESCRIBE CURRENT MEDICAL PROBLEM/REASON FOR TODAY'S VISIT/ IF ACCIDENT, HOW IT HAPPENED:

_____

_____

IF INJURY IS A RESULT OF WORK – PLEASE COMPLETE

DATE OF ACCIDENT: _____BRIEF DESCRIPTION OF HOW ACCIDENT HAPPENED: _____

_____

CLAIM#:_____ NAME AND ADDDRESS OF PERSON RESPONSIBLE FOR BILLING: _____

_____

IF INJURY IS A RESULT OF A MOTOR VEHICLE ACCIDENT – PLEASE COMPLETE

DATE OF ACCIDENT: _____ CLAIM#:_____ AUTO INS. CO. _____

AUTO INS. CO ADDRESS: _____

OTHER PHYSICIANS TREATING YOU: _____

PREVIOUS OR OTHER MEDICAL PROBLEMS/INJURIES: _____

LIST ANY PREVIOUS HOSPITALIZATIONS/SURGERIES: _____

PRESENT MEDICATIONS: _____

ALLERGIES TO MEDICATIONS: _____ ALLERGIC TO LATEX? YES ☐ NO ☐

FEMALES ONLY: ARE YOU PREGNANT, PLANNING A PREGNANCY OR NURSING A CHILD? YES ☐ NO ☐

DO YOU SMOKE? YES ☐ NO ☐ # OF YEARS:_____ HOW MUCH? _____

DO YOU REGULARLY DRINK ALCOHOL YES ☐ NO ☐ HOW MANY OUNCES/BEERS A DAY? _____

DO YOU REGULARLY DRINK COFFEE? YES ☐ NO ☐ HOW MANY CUPS PER DAY? _____

PERSONAL MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING, **PLEASE CIRCLE**: NONE

CHEST PAIN/PRESSURE/TIGHTENING	ASTHMA	HIGH CHOLESTEROL
HIGH BLOOD PRESSURE	SHORTNESS OF BREATH	HEART ATTACK
CANCER	TB/LUNG DISORDER	KIDNEY DISEASE
STROKE	DIABETES	ULCERS
ARTHRITIS	OSTEOPOROSIS	DIGESTIVE PROBLEMS
HYPOTHYROIDISM	DIFFICULTY HEARING	HEPATITIS
ALLERGIES/ECZEMA	GLAUCOMA	CATARACTS
SEIZURES	URINARY INFECTIONS	HIV/AIDS

ASSIGNMENT OF BENEFITS

PAYMENT IS TO BE MADE WHEN PATIENT CARE IS RENDERED

EXCEPT

IN THE CASE WHEN WE CAN PARTICIPATE IN THE HMO YOU ARE ENROLLED IN. THEN THE FOLLOWING IS APPLICABLE.

I ASSIGN DR. TOBENNA OKEZIE, BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY HIM OR HIS ORDER.

THE FOLLOWING IS APPLICABLE TO ALL PATIENTS:

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS ANY CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO DR. TOBENNA OKEZIE.

I AUTHORIZE ANY PHYSICIAN, HOSPITAL OF MEDICAL CARE FACILITY TO PROVIDE ALL INFORMATION ON MY MEDICAL HISTORY AND TREATMENT TO THE ABOVE NAMED PROVIDER.

I AUTHORIZE DR. TOBENNA OKEZIE TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER, FOR ANY REASON, ON MY BEHALF.

PATIENT/GUARDIAN SIGNATURE _____ **DATE:** _____