

Family History: **Age** **Health** **Cause of Death** **Age of Death**

1. Father _____

2. Mother _____

3. Siblings _____

4. Spouse _____

5. Children _____

Diseases:

Relationship

A. Cancer _____

B. Heart Trouble _____

C. High Blood Pressure _____

D. Stroke _____

E. Seizures or Epilepsy _____

F. Diabetes _____

G. Tuberculosis _____

H. Heart Attack (Over age of 50) _____

I. Heart Attack (Under age of 50) _____

Medical information/assignment of benefits

I verify that all the information is correct and authorize the release of any pertinent medical information to **Dr. Agoro**.

Signature: _____ Date: ____/____/____

I hereby authorize **Dr. Agoro** to furnish my insurance company and information acquired during the course of any of my examination or treatment. I understand that I am responsible for any charges and that is due at the time of service. In the event **Dr. Agoro** should elect to file insurance on my behalf for hospital or surgical, I request that payment be made to my physician.

Signature: _____ Date: ____/____/____

The undersigned agrees that all service rendered on a paid basis only. If collection becomes necessary, the undersigned shall pay costs including all attorney's fees.

