# ADESUBOMI AGORO MD PA

PULMONARY, CRITICAL CARE, AND SLEEP DISORDER SPECIALIST

**8401 Jacksboro Hwy.Ste.700**
**Lakeside, TX 76135**

**1100 Pennsylvania Ave .**
**Fort Worth, TX 76104**

**Ph:(817)-763-5550**
**Fax:(817)-763-5715**
**Alternate Fax:(817)-338-0401**

Date:___/___/___

Patient name:_____________________________________________________________________
- Last First Middle Initial

Mailing Address:__________________________________________________________________ -
Street Apt No. City State Zip code

Home Phone No.______________________________ Work Phone No.__________________

Preferred Day Time Phone No._________________________ Birth Date:___/___/___ Age:_____

Social Security No.__________________________ Drivers License No.______________________

(Circle one) Sex: M F Marital Status: Married Single Separated Divorced Widowed

Employment Status: Fulltime Part-time Self-Employed Retired Unemployed Full-Time Student Military

Primary Care Physician:______________________ Physician Referred by:___________________

Physician Ph.______________________________ Physician Fax:__________________________

In Case of Emergency:________________________ Phone No:________________________ -
contact name/relationship to patient

**Insurance Information**

Primary Insurance
Company Name:___________________________________________________________________

ID No:____________________________ Group No:______________________________________

Effective date of insurance:___/___/___ Employer/Phone No:________________________________

Insured name:___________________ Birth Date:___/___/___ Social Security No:_______________

**Secondary Insurance**
Company name:___________________________________________________________________

ID No:_____________________________________ Group No:______________________________

Effective Date of Insurance:___/___/___ Employer/Phone No:_______________________________

Insured Name:____________________ Birth Date:___/___/___ Social Security No:______________

## Patient Questionnaire

**I.** Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name________________________ Relationship____________________ DOB_________________

Name________________________ Relationship____________________ DOB_________________

**II**. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name________________________ Relationship____________________ DOB_________________

Name________________________ Relationship____________________ DOB_________________

**III.** Please print the address of where you would like your postcards and/or correspondence from our office sent if other than your home.

________________________________________________________________________________
________________________________________________________________________________

**IV.** Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": YES_________ NO__________

**V.** Please print the telephone numbers where you want to receive calls about your appointment, lab and x-ray results, other health care information if other than your home phone number: ( )________

- **I am fully aware that a cell phone is not a secure and private line**

**VI.** Can confidential messages be left on your telephone answering machine?
YES__________ NO___________

**VII.** I am fully aware my health information will be transmitted by electronic transmission, by fax transmittal, by internet or by e-mail.

PATIENT
SIGNATURE:______________________________________________ DATE_______________
(guardian if under age of 18 years)

**Authorization and Acknowledgement**

I authorize the Physician's office to furnish my insurance company any information during the course of my examination or treatment. I understand that I am responsible for all charges and that full payment is due at the time of service. In the event that the Physician's office should elect to file insurance on my behalf for service rendered, I request that payment be made directly to the Physician's office. I consent to treatment and medical care by the providers of **Dr. Agoro.** I also authorize release of all information necessary to a specialist should I be referred for medical care.

Signature:_________________________________________________ Date:____/____/____

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**Fort Worth, TX 76104**

## Certificate to Return to Work

Patient:______________________

Assisted By:____________________

Has been under my care from:_______ to_______

And is able to return to work on:_______________

Dr.____________________ Date:______________

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# REQUEST INFORMATION FOR NEW PATIENT APPOINTMENT

Appt: ________________________ @ _____________________ to see Dr. ______________________

Location:

| | | |
|---|---|---|
| 8401 Jacksboro Hwy. Ste. 700<br>Lakeside, TX 76135 | 2621 Matlock Rd. Ste.101<br>Arlington, TX 76105 | 1161 Wilshire Blvd.Ste 115<br>Burleson, TX 76028 |
| 508 S. Adams St. Ste.200<br>Fort Worth, TX 76104 | 1100 Pennsylvania ave<br>Fort Worth, TX 76104<br>Ph:817-763-5550<br>Fax:817-763-5715 | 1339 East Street<br>Graham, TX 76450 |

PATIENT DEMOGRAPHICS

Patient Name:_________________________________________ D.O.B: _____/_____/_______

Address:_________________________________________________________________________

Social Security Number: _______- _______- _______ Phone Number: (_____) _____-______

REASON FOR APPOINTMENT:

PFT Sleep Consultant Other—DX:_______________________________________

Has Patient had: CT Scan CXR (Within last 30 days)

Where? ______________________________ Can patient bring in films/CD to visit? Yes No

***** Please fax current insurance card(s), last two office notes, recent labs, PFT/spirometry, sleep studies, CT scans/CXR, physician notes and medication lists.*****

INSURANCE INFORMATION

Company name:____________________________ Type: HMO PPO

Referral required: Yes No

Insured name/D.O.B: _______________________________________________________

ID#:_______________________________________________________________________

REFERRING PROVIDER INFORMATION: ***Please send referral***

Referred by:__________________________________________________________________

Person scheduling:_____________________________________________________________

Phone number:(_____) _____-_____ Fax number:(_____) _____-___________

PCP: ___________________________________ Phone:(____) ________-_______________

(If other than referring provider) Fax:(____) ________- __________

INFORMATION TAKEN BY:_____________________________________________________

**Warning:** This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED.** If you are not the intended recipient, please notify us and shred the information. Thank you for your cooperation

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## DAILY SUMMARY OF CHARGES AND PAYMENT FORM

Name:______________________________________________________________________

Date of batch:________________________________________________________________

Total charges/fees:______________________________________________________

Total cash:____________________________________________________________

Total credit cards:______________________________________________________

Total checks:__________________________________________________________

Total payments:________________________________________________________

Note: “Total payments must be the sum of “total cash,” “total credit cards,” and “total checks.”
Attach charge tickets, payments, and tapes to the back of this form, and return the form to your supervisor

## DAILY DEPOSIT LOG

Practice site:_________________________________________________________________

| **Date** | **Deposit Total** | **Prepared By** |
| --- | --- | --- |

## REQUEST FOR EDIT/CORRECTION

Account number:_____________________________________________________________________

Patient name:_______________________________________________________________________

Date of service to be edited:_________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Requester:__________________________________________________________________________

Date:_______________________________________________________________________________

Approval granted by:________________________________________________________________

Date:_______________________________________________________________________________

Notes of approval not granted:______________________________________________________

_______________________________________________________________________________

***Please attach any available, appropriate documentation.***

# *Consent For Laser Hair Removal*

***Patient Name:***___________________________________________

I understand that the purpose of this procedure is to remove unwanted hair. There are several alternatives to laser hair removal treatment including but not limited to electrolysis, shaving, waxing and plucking or no treatment at all.

I understand that the possible risks of the procedure include pain, purpura, swelling, redness, bruising, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity and pigmentation and unforeseen complications. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment sessions.

I understand that a single procedure will most likely fail to completely remove all my unwanted hair in the area treated. Multiple treatments are required. Individual response will vary according to skin types, hair color, degree of tanning, follow up care, and the body area being treated.

I understand the treatment may be painful, but this is typically manageable without any pain relief medication. Color changed, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin. This may take several months to resolve, if at all. Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause or worsen this condition. Blistering of the skin may occur. Scarring happens but is uncommon.

I understand that the operator is not an agent of The Wellness Village; and that Lumenis Inc & Lyra Laserscope is not an agent of The Wellness Village for the purposes of the procedure or treatment. I hereby hold Lumenis Inc & Lyra Lasercope, The Wellness Village & any of its affiliates , harmless of any errors and omissions of the doctor in connection with the procedure or treatment.

I have been asked at this time whether I have any questions about this procedure and do not. I understand the procedure, and risks, accept the risks, and request that this procedure be performed on me by the doctor or other qualified staff.

Signature of Patient _________________________________________ Date __________________

Signature of Practitioner _____________________________________ Date__________________

Signature of Witness ________________________________________ Date__________________

Lumenis, Inc, Lyra Laserscope, The Wellness Village