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)-870-1280

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:_____
If other than primary care physician

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:_____

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

1. Father_____

2. Mother_____

3. Siblings_____

_____

_____

_____

4. Spouse:_____

5. Children:_____

_____

_____

_____

Diseases:

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 of the information is correct and I authorize the release of any pertinent Information to **Dr.Agoro.**

Signature:_____ Date:____/____/____

I hereby authorize **Dr.Agoro** to furnish my insurance company any information acquired during the course of any of my examination or treatment. I understand that I responsible for any charges and that full payment 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 is rendered on a paid basis only. If collection becomes necessary, the undersigned shall pay costs including all attorneys' fees.

5. I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.

6. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper pigmentation.

7. 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.

8. 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.

9. 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.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGEMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release _____(individual) And _____(facility) and _____(doctor) from all liabilities associated with the above indicated procedure.

Signature of Patient _____ Date _____

Signature of Practitioner _____ Date _____

Signature of Witness _____ Date _____

Lumenis Inc, Lyra Laserscope, The Wellness Village

Informed Consent
For Removal/Reduction of Brown/Age Spots, Rosacea & Spider Veins

Name:_____ Date:_____

I authorize _____, to perform the procedure. The light pulsed system may dramatically reduce darkly pigmented sunspots and spider veins. More than one laser session may be necessary to achieve desired results. However, other treatments, including skin care products, are often needed to blend color, reduce sun damage, and give the best results. The FDA has given the clearance for removal of brown spots, spider veins and rosacea.

The skin treated will be red and swollen with fine, thin scabs forming. Keep the treated areas covered with Polysporin and Aquaphor until the thin scabs fall off. This process will take anywhere from 1-3 weeks. It could take as long as 3-6 months in some rarer cases. Do not scratch the scabs, as that can cause scarring.

We are unable to treat clients that are on ACCUTANE and PHOTOSENSITIZING medications. Clients using ANTICOAGULANTS should be noted.

The following problems may occur with treatment:

1. **Scarring:**The light pulsed system can create a bruising and a moderate burn or blister to the skin. For an effective treatment, the power (joules) needs to be just below the blistering point which means skin will be red. There is a risk of scarring.

2. **Hyper-pigmentation** (browning) and **Hypo-pigmentation** (whitening) have been noted after treatment, especially with a darker complexion. This usually resolves within weeks, but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have a lot of color in your skin, a skin lightening cream will be advised to reduced the melanin in your skin before the treatment. Avoiding sun exposure after the treatment is crucial to reduce the risk of color change.

3. **Infection:** Although infection following pulsed light treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a laser treatment. This applies to both individuals with a past history if herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatment including antibiotics might be necessary. **If you have a history of herpes simplex virus in the treated area we recommend preventative therapy.**

4. **Bleeding:** Pinpoint bleeding is rare but can occur following brown spot and spider vein treatment procedures. Should bleeding occur, additional treatment might be necessary.

PAYMENT PLAN

Patient Name_____ Account #_____

Address_____

Home Phone_____ Work Phone _____ Mobile_____

1) Balance Due $_____

2) 1.5% Finance Charge Per Month: 1st $_____

2nd $_____

3rd $_____

1st Payment $_____Due Date_____

2nd Payment $_____Due Date_____

3rd Payment $ _____Due Date_____

I hereby agree to pay Dr. Agoro the sum of $_____, <u>within 90 DAYS.</u>

I understand/agree that the balance must be paid no later than

_____.

I understand that failure to make a payment <u>within 10 DAYS</u> of the due date will result in alternative collection procedures.

I understand and agree that I will be responsible for any charges, i.e. attorney fees, collection fees, if the office of Dr. Agoro should have to take necessary steps in the form of further collection procedures to collect this balance from me.

_____ _____

Patient Signature Date

_____ _____

Witnessed (OFFICE STAFF ONLY) Date

To whom it may concern:

ADESUBOMI AGORO MD PA

PULMONARY, CRITICAL CARE, AND SLEEP DISORDER SPECIALIST

INFORMATION NEEDED PRIOR TO APPOINTMENT WITH DR. AGORO

To:_____ **Fax:**_____

From:_____ **Phone:**_____

RE:_____ **DOB:**_____

Check List: **Appt:**_____

_____ **Patient Demographics**

_____ **Copy of Insurance Cards**

_____ **Labs**

_____ **Referral (HMO, Amerigroup SSI. Etc)**

_____ **Reason for visit (Dictation/office notes)**

Information below is needed if pt is being seen for surgery clearance:

_____ **What kind of surgery is pt having**

_____ **Doctor performing surgery**
(Along with contact information)

_____ **Location of surgery**
(Hospital, Out-Patient facility, etc.)

Please fax to 817-870-1280

Dr. Agoro M.D.

RELEASE OF PATIENT INFORMATION

I consent and authorize the release of any normal and/or abnormal test results to the following persons:

____ Myself

____ Voice Mail:_____

____ My Spouse: _____

____ My Child/Children: _____

____ My Parent (s): _____

____ Other: _____

I wish to be contacted in the following manner (Check all that applies):

____ Home Telephone: _____

____ Permission given to leave message with detailed info on home telephone

____ Leave name/doctor with callback number only

____ Cell phone:_____

____ Permission given to leave message with detailed info on Cell Phone

____ Leave name/doctor with callback number only

____ When unable to contact me by phone, a written communication may be sent to my home address.

Other:_____

_____ _____

(Patient Signature) (Date)

_____ _____

(Print Name) Date of Birth

ADESUBOMI AGORO MD PA

PULMONARY, CRITICAL CARE, AND SLEEP DISORDER SPECIALIST

PATIENT SURVEY

On a scale from 1 (= worst) to 10 (=best), please rate your experience for each clinic

BURLESON	LAKESIDE	DOWNTOWN
Cleanliness of office _____	Cleanliness of office _____	Cleanliness of office _____
Friendliness of front desk _____	Friendliness of staff _____	Friendliness of staff _____
Overall visit _____	Overall visit _____	Overall visit _____

Comments:

_____

_____

_____

_____

_____

_____