DR. GAFAR ADESOJI, INTERNAL MEDICINE
PROGRESSIVE PHYSICIANS PRACTICE, PLLC
8412 AIRWAYS BLVD, SOUTHAVEN, MS 38671
PHONE: (662) 536-2100 FAX: (662) 536-2211

PATIENT:

Last Name:_____ First Name:_____ MI:_____

Address:_____ City:_____ State:_____ Zip:_____

Soc. Sec#_____ Date of Birth:_____ Sex:_____ Race:_____

Telephone Number:_____ E-mail:_____

Circle One: Minor Single Married Divorced Widowed Separated Language Spoken_____

Preference for Reminder: Phone Mail Email Ethnicity: Hispanic Non-Hispanic Decline

Employer:_____ Work Number:_____

EMERGENCY CONTACT (OTHER THAN SPOUSE)

Name:_____ Relationship to Patient:_____Telephone:_____

Address:_____City:_____ State:_____ Zip:_____

Whom should we thank for referring you:_____

RESPONSIBLE PARTY:

Name:_____ Relationship to Patient:_____

INSURANCE:

Company Name:_____ ID#:_____ Group#:_____

Policy Holder:_____ Relationship to Patient:_____

Company Name:_____ ID#:_____ Group#:_____

Policy Holder:_____ Relationship to Patient:_____

BENEFITS AUTHORIZATION:

I authorize treatment of the patient named above and agree to pay all fees and charges billed by Progressive Physicians Practice. I request that payment of authorized Insurance Company or third party insurance be made to Progressive Physicians Practice or one of its physicians if assignment is accepted in which case agree to pay any deductible, co-payment or disallowed charges. If assignment is not accepted I agree to pay the entire amount due. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, the Division of Medicaid and their Fiscal Agent or any third party insurance, any information needed to determine these benefits. If you default on any payment you will be responsible for any COLLECTION AGENCY CHARGES.

Signature:_____ Date:_____

PROGRESSIVE PHYSICIANS PRACTICE
AUTHORIZATION FOR DISCLOSER OF HEALTH INFORMATION

Patient Name:_____
Date of Birth:_____ Phone:_____
Address:_____
City:_____ State:_____ Zip:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make this discloser:

Name of Hospital, Clinic, and/or Facility:

_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

3. The type and amount of information to be used or disclosed is as follows: (Includes dates where appropriate.)

____ Compare health records
____ Physical exam
____ Immunization records
____ Other (please specify:_____
____ Lab results/ X-ray reports
____ Consultation reports

4. I understand that the information in my health record may include information relating to sexual transmitted disease, acquired immunodeficiency syndrome (AIDS) or human Immunodeficiciency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization

PROGRESSIVE PHYSICIANS PRACTICE, PLLC

8412 AIRWAYS BLVD
SOUTHAVEN, MS 38671
662-536-2100 PHONE
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6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management department at PROGRESSIVE PHYSICIANS PRACTICE 8412 AIRWAYS BLVD. SOUTHAVEN MS. 38671. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy, unless otherwise revoked; this authorization will expire in 60 days.

_____
PATIENT SIGNATURE (OR LEGAL REPRESENTATIVE)

_____
DATE

REASON FOR VISIT:

Why are you here today? _____

_____

MEDICAL HISTORY:

When was your last physical exam? _____

Physician's Name _____ Phone# _____

1. Are you currently under medical treatment? Yes____ No____

Please describe_____

_____

2. Have you ever had any serious illnesses or operations? Yes____ No____

Please describe_____

_____

3. Are you currently taking any medications? Yes____ No____

Please describe_____

_____

4. Do you smoke? Yes____ No____

5. Do you use alcohol? Yes____ No____

6. Do you use any illegal drugs? Yes____ No____

7. Have you had any allergic reaction to the following:

Local Anesthetics (Novocain)	Yes____ No____
Penicillin or other Antibiotics	Yes____ No____
Sulfa Drugs	Yes____ No____
Barbiturates(Sleeping Pills)	Yes____ No____
Sedatives	Yes____ No____
Iodine	Yes____ No____
Aspirin	Yes____ No____
Other Please describe:_____	

WOMEN ONLY:

When was your last menstrual period? _____

Do you get regular periods? Yes____ No____

Are you taking birth control? Yes____ No____

Have you ever been pregnant? Yes____ No____

HAVE YOU EVER HAD THE FOLLOWING:
CIRCLE ONE

Anemia (low blood count)	yes no	Liver Disease	yes no
Anorexia (no appetite)	yes no	Low Blood Pressure	yes no
Arthritis	yes no	Measles	yes no
Asthma	yes no	Migraine Headaches	yes no
Back Problems	yes no	Mitral Valve Prolapse	yes no
Bleeding Tendency	yes no	Mumps	yes no
Blood Disease	yes no	Multiple Sclerosis	yes no
Cancer	yes no	Pacemaker	yes no
Chemical Dependency (addicted to drugs)	yes no	Pneumonia	yes no
Chemotherapy	yes no	Polio	yes no
Chicken Pox	yes no	Prostate Problem	yes no
Chronic Fatigue Syndrome	yes no	Psychiatric Care	yes no
Congenital Heart Lesions	yes no	Respiratory Disease	yes no
Cough (persistent or bloody)	yes no	Rheumatic Fever	yes no
Diabetes	yes no	Scarlet Fever	yes no
Emphysema	yes no	Shortness of Breath	yes no
Epilepsy	yes no	Sinus Trouble	yes no
Glaucoma	yes no	Skin Rash	yes no
Heart Murmur	yes no	Stroke	yes no
Heart Disease	yes no	Thyroid Problems	yes no
Hepatitis Type____	yes no	Tonsillitis	yes no
Hernia	yes no	Tuberculosis	yes no
Herpes	yes no	Ulcer	yes no
High Blood Pressure	yes no	Venereal Disease	yes no
HIV/ AIDS	yes no	Any Other Conditions	yes no
Jaundice	yes no	Please list and describe_____	
Kidney Disease	yes no	_____	
Latex Sensitivity	yes no	_____	

ASSIGNMENT AND RELEASE:

I Hereby authorize payment directly to _____ for all benefits otherwise payable to me for services rendered. I understand that I am directly responsible for ALL charges whether or not paid by insurance and for ALL service rendered on my behalf or my dependents.

Signed_____ Date _____

PROGRESSIVE PHYSICIAN PRACTICE

FAMILY HISTORY

PLEASE INDICATE IF A FAMILY MEMBER HAS OR HAD ONE OF MORE:

*ALCOHOLISM- MOTHER-FATHER-SISTER-BROTHER-NONE

*ANEMIA-MOTHER-FATHER-SISTER-BROTHER-NONE

*ASTHMA-MOTHER-FATHER-SISTER-BROTHER-NONE

*BLOOD DISEASE-MOTHER-FATHER-SISTER-BROTHER-NONE

*CANCER-MOTHER-FATHER-SISTER-BROTHER-NONE
PLEASE LIST WHICH TYPE OF CANCER_____

*CONVULSIONS/EPILEPSEY-MOTHER-FATHER-SISTER-BROTHER-NONE

*DEAFNESS-MOTHER-FATHER-SISTER-BROTHER-NONE

*DIABETES-MOTHER-FATHER-SISTER-BROTHER-NONE

PLEASE INDICATE WHICH TYPE OF DIABETES (TYPE I OR TYPE II)

*DRUG ABUSE-MOTHER-FATHER-SISTER-BROTHER-NONE

*HEART DISEASE-MOTHER-FATHER-SISTER-BROTHER-NONE

*HIGH CHOLESTEROL-MOTHER-FATHER-SISTER-BROTHER-NONE

*HIGH BLOOD PRESSURE-MOTHER-FATHER-SISTER-BROTHER-NONE

*HIV/AIDS-MOTHER-FATHER-SISTER-BROTHER-NONE

*IMMUNE PROBLEM-MOTHER-FATHER-SISTER-BROTHER-NONE

*KIDNEY DISEASE-MOTHER-FATHER-SISTER-BROTHER-NONE

*LIVER DISEASE-MOTHER-FATHER-SISTER-BROTHER-NONE

*MENTAL DISORDER-MOTHER-FATHER-SISTER-BROTHER-NONE

*MENTAL RETARDATION-MOTHER-FATHER-SISTER-BROTHER-NONE

*MIGRAINE HEADACHES-MOTHER-FATHER-SISTER-BROTHER-NONE

*NASAL ALLERGIES-MOTHER-FATHER-SISTER-BROTHER-NONE

*THYROID PROBLEMS-MOTHER-FATHER-SISTER-BROTHER-NONE

*TUBERCULOSIS-MOTHER-FATHER-SISTER-BROTHER-NONE

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT OF RECEIPT

I, _____ have received a copy of Progressive Physicians Practice's notice of Privacy Practices and I have been given an opportunity to ask questions.

_____ _____

Signature of Patient/Parent Date

PROGRESSIVE PHYCISIONS PRACTICE, PLLC
GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT

I. THE UNDERSIGNED PATIENT OR RESPONSIBLE PERSON, HAVING REGISTERED AT PROGRESSIVE PHYSICIANS PRACTICE FOR THE PURPOSE OF OBTAINING HEALTH SERVICES, DO HEREBY VOLUNTERILY CONSENT TO SUCH DIAGNOSTIC AND TREATMENT SERVICES AS NIGHT BE PROVIDED BY OR THE DIRECTION OF A PHYCISIAN OR OTHER QUALIFIED HEALTH CARE PROVIDER IN THE CLINIC.

I, RECOGNIZE THAT I HAVE THE RIGHT TO REFUSE ANY SPECIFIC DIAGONOSTIC OR TREATMENT SERVICE WITHOUT JEOPERDIZING MY RIGHT TO RECEIVE HEALTH SERVICES AT THE CLINIC. I ALSO RECOGNIZE THAT I WILL BE ASKED TO SIGN A SPECIFIC CONSENT, AS NEEDED, FOR SURGICAL AND OTHER SPECIAL PROCEDURES INCLUDING GENERAL AND/OR EXTENSIVE LOCAL ANESTHESIS.

I AM AWARE THAT HEALTH SERVICES ARE NOT BASED ON EXACT SCIENCE; BUT ARE PROVIDED ACCORDING TO JUDGEMENT OF THE PHYSICIAN, DENTIST, OR OTHER QUALIFIED HEALTH CARE PROVIDER OF THE CLINIC. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF ANY DIAGNOSTIC OR TREATMENT SERVICES, FURTHER, I AUTHORIZE THAT CLINIC TO FURNISH REQUESTED PATIENT INFORMATION TO REQUISITE LEGAL, HEALTH, SOCIAL, AND GOVERNMENT ENTITLES, AS NEEDED.

I CERTIFY THAT I HAVE THE LEGAL CAPACITY TO GIVE THIS CONSENT FOR DIAGONISTIC AND TREATMENT SERVICES ON THE PATIENT NAMED BELOW, I FURTHER CERTIFY THAT THS FORM HAS BEEN FULLY EXPLAINED, TO ME AND THAT I UNDERSTAND ITS CONTENTS.

PRINT NAME OF PATIENT	DATE	SIGNATURE OF PATIENT

SIGNATURE OF STAFF	RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

COMPLETE THIS SECTION ALSO IF PATIENT IS A MINOR SEEKING REPRODUCTIVE HEALTH CARE.

I RECOGNIZE THAT, ACCORDING TO THE LAWS OF THAT STATE OF MISSISSIPPI. PARENTAL CONSENT IS NOT REQUIRED IN THAT CADE OF A MINOR SEEKING TREATMENT OF A VENEREAL DISEASE OR A FEMALE, REGARDLESS OF THE AGE OR MARITAL STATUS, SEEKING DIAGNOSTIC OR TREATMENT SERVICE IN CONNECTION WITH PREGNANCY OR CHILDBIRTH.

[illegible]	DATE	[illegible]

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TERMS OF PAYMENT AFTER YOUR INSURANCE HAS BEEN FILED AND PAYMENT HAS BEEN POSTED TO YOUR ACCOUNT

THE POLICY OF PROGRESSIVE PHYSICIANS PRACTICE, LL., IS TO ASK FOR PAYMENT ON BALANCES DUE ON YOUR ACCOUNT. WE WILL FILE YOUR INSURANCE CLAIM FOR PAYMENT FOR ALL COVERED SERVICES PROVIDED TO YOU IN THE OFFICE.

THIS IS TO ADVISE YOU THE PATIENT OF OUR TERMS FOR FILING YOUR INSURANCE CLAIM. ONCE YOU THE PATIENT HAS SEEN THE DOCTOR WE WILL FILE YOUR INSURANCE CLAIM. WE WILL RECEIVE AND EXPLANATION OF BENEFITS FROM YOUR INSURANCE COMPANY AT THAT TIME WE WILL POST THE PAYMENTS AND OR THE ADJUSTMENTS TO YOUR ACCOUNT.THE AMOUNT YOUR INSURANCE PUTS TO YOUR RESPONSIBILITY YOU WILL BE RESPONSIBLE FOR PAYING. WE WILL SEND YOU A STATEMENT FOR ANY BALANCE DUE FROM YOU. IF YOU NEED TO SEE THE DOCTOR AND YOU HAVE A BALANCE ON YOUR ACCOUNT, THIS BALANCE WILL NEED TO BE TAKEN CARE OF BEFORE SEEING THE DOCTOR.

BY SIGNING BELOW, YOU ARE STATING THAT YOU UNDERSTAND THE ABOVE AND AGREE TO PAY ANY BALANCES DUE FROM YOU AFTER YOUR INSURANCE HAS BEEN FILED BY OUR OFFICE. IF YOU DO NOT UNDERSTAND PLEASE ASK ONE OF THE OFFICE STAFF AND THEY WILL BE GLAD TO ASSIST YOU.

_____Print Name

_____Sign Name

_____Date

_____Witness Printed

_____Witness Signed

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AGREEMENT FORM REGARDING SCHEDULE PRESCRIPTIONS

BY SIGNING THIS FORM I AGREE THAT I DO NOT USE MULTIPLE PHYSICIANS FOR TREATMENT OF BACK PAIN AND ANY OTHER PROBLEM THAT REQUIRES TREATMENT WITH NARCOTIC MEDICATION. I ALSO UNDERSTAND THAT IF I RECEIVE TREATMENT AND/OR NARCOTIC PRESCRIPTIONS BY MULTIPLE PHYSICIANS AND IF I USE MULTIPLE PHARMACIES TO GET MY PRESCRIPTIONS FILLED THAT I AUTOMATICALLY BREAK THIS AGREEMENT. AT THAT TIME I WILL NEED TO FIND ANOTHER PHYSICIAN FOR TREATMENT. BY SIGNING THIS FORM I AM AGREEING THAT I HAVE READ AND UNDERSTAND IT COMPLETELY.

NAME: _____

DATE: _____