Dr. Julius O. Ajayi
First Foundation Medical Clinic,
P.C. **Patient Registration Form**

PERSONAL INFORMATION

Name: _____ SS #:_____
Street Address:_____ Date of birth:_____
City: _____ State: _____ Zip: _____ Marital Status: S☐ M☐ W☐ Sep☐ D☐
Telephone # Home: _____ Work: _____ Cell: _____
Email Address:_____ Referred by: _____
Spouses Name:_____
Spouse's employer/ address:_____
Emergency contact:_____Tel# _____ Relationship: _____

PATIENT EMPLOYER INFORMATION

Employer name: _____Tel#_____
Employer street address_____ City/ State _____ Zip_____
Patient's occupation_____

INSURED PERSON (IF NOT PATIENT)

Name _____ Tel#_____
Street Address_____City/ State _____ Zip _____
Relationship to patient_____ Date of birth:_____

INSURANCE/ PAYMENT INFORMATION

Primary Insurance Company Name: _____
ID #:_____ Group #:_____Tel#:_____
Secondary Insurance Company Name:_____
ID #:_____ Group #:_____Tel#:_____
Medicaid # (if applicable):_____Medicare # (if applicable): _____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signature: _____

I hereby authorize Dr. ____ to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Dr. Ajayi or the party that accepts assignment.

I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date: _____ Signature: _____

Name:_____SS#:_____

General Medical Information

Describe the current medical problem / reason for today's visit:_____

Present medications:_____Allergies to medications:_____ Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergents_____ Other physicians currently treating you: _____ Previous or other medical problems: _____ List any previous surgeries or hospitalizations (include number or miscarriages and live births):_____ Females only: Are you pregnant, planning a pregnancy or nursing a child? Yes☐ No☐

Do you smoke? Yes☐ No ☐ Cigarettes☐ Pipe☐ Cigars☐ No. of years__ How much?___

Interested in stopping?

Do you regularly drink alcohol? Yes☐ No ☐ How many ounces/beers per day?_____

Do you regularly drink coffee? Yes☐ No ☐ How many ounces/beer per day?_____

Are you under a lot of pressure at work? Yes☐ No☐ Please describe:_____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following: (check all that apply):

Chest pain/pressure/ tightening	☐	Asthma	☐	Kidney disease	☐	Diabetes	☐
Hypertension	☐	Dizzy spells	☐	Shortness of breath	☐	Heart attack	☐
Stroke	☐	Ulcers	☐	TB/ Lung disorder	☐	Cancer	☐
Headaches	☐	Arthritis	☐	Skin disorders	☐	Glaucoma	☐
Difficulty hearing	☐	Hepatitis	☐	Allergies/ Eczema	☐	Cataracts	☐
Depression	☐	Memory Loss	☐	Digestive problems	☐	Blood in stool	☐
Hemorrhoids	☐	Frequent Urinary Infections	☐	Other	☐		

IMMUNIZATIONS

(Year last received, if known)

Smallpox_____
Tetanus_____
Typhoid_____
Polio_____
Influenza_____
Pneumonia_____
Rubella_____
Hepatitis_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High Blood Pressure	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
ECZEMA/ Psoriasis	☐	☐	☐	☐	☐	☐
Heart Attack/ Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐

MISCELLANEOUS NOTES

_____

_____

_____

_____

_____

First Foundation Medical Clinic
Julius O. Ajayi, MD
2930 Horizon Park Dr. Ste.C
Suwanee, GA 30024

Phone (678)546-2840

Fax (678)546-2844

Patient Acknowledgement/Agreement Form

Please take the time to read this form prior to signing. Please direct any and all questions to the secretary.

Payment for Service

Payment is required at the time of service. We accept cash, check, and credit cards. We are unable to bill you for your office visit co-pay. We will collect all co-pays and balances prior to seeing the physician.

Returned Checks

We charge an administrative fee of $40.00 for returned checks. After one returned check we will no longer be able to accept checks from you in any amount.

Courtesy Filing of Claims

As a courtesy, we will file a claim for each service with your insurance company. Copayments and any other stated patient financial responsibility must be paid at each service. Should your insurance company deem all or part of our charges for your care today, "non-payable", you will be responsible for payment on those charges. To avoid misunderstandings, please ask to speak to the office manager.

Patient Financial Responsibility

Balances that remain outstanding for thirty days or more {regardless of the reason) become patient responsibility. It is the patient's responsibility to keep up with the office to ensure that their claims are being honored. As a patient I acknowledge and consent that any balance over sixty days past due will be forwarded to the collections agency.

Request for Services

The office requires a minimum of 72 hours notice for any service that the patient requires, including but not limited to medication refills, record release requests, form filling, etc. Please also note that there is a charge for the release of records and the filling of any forms by the physician.

Appointment Cancellation Policy

A 24 hour notice period is required to change/cancel scheduled appointments. Failure to do so will result in a $20 fee being assessed to your account.

_____.
Patient Signature

_____.
Date

First Foundation Medical Clinic
Julius O. Ajayi, MD
2930 Horizon Park Dr. Ste.C
Suwanee, GA 30024

NAME:_____ SOCIAL SECURITY#:_____

DATE OF BIRTH: _____

I understand that as a patient at the above medical clinic my records are held and kept confidential and can be shared with only me.

However, if you ever have information you need to give to me, you

☐ are authorized

☐ not authorized

to leave a message on my answering machine.

You are also authorized/ not authorized to give my information to my spouse named _____.

You are also authorized/ not authorized to give my information to

_____. _____.

Name Relationship

_____. _____.

Name Relationship

_____. _____.

Name Relationship

I have read the above and do affix my signature fully understanding that my medical information will/ will not be released to the persons I have listed above.

_____. _____.

Name Date

Signature:_____

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Suwanee, GA 30024

I,_____, have received a copy of First Foundation Medical Clinic, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient Date