ULNACS Medical Care, P.C.

Godswill O. Okoji, M.D., F.A.C.P.
3331 Toledo Terrace Suite 108
Hyattsville, MD 20782
Office: (301) 408-4111
Fax: (301) 408-4600

1809 Benning Road NE
Washington, DC 20002
Office: (202) 399-4400

PATIENT REGISTRATION FORM

***** PLEASE PRINT *****

Name: _____ Date of Birth: _____-____-_____

Sex: M/F/L/G/T Marital Status: M/ S/ W/ D/ Sep Social Security Number: _____-_____-_____

Address: _____

City:_____ State: _____ Zip Code: _____

Home Phone: _____ Cellular: _____ Work: _____

E-mail Address: _____

Primary Insurance Carrier: _____ Insurance ID #_____

Secondary Insurance Carrier:_____ Insurance ID #_____

Policy Holders Name: _____ Date of Birth:_____- ____- _____

Emergency Contact Person: _____ Relation To You: _____

Address/ City/ State/ Zip Code: _____

Emergency Contact Phone Number: _____

Patient Assignment of Benefits (All Insurance)

I, Hereby authorize payment of surgical/medical benefits to Dr. Godswill O. Okoji, for services rendered by him or ULNACS Medical Care, P.C. Professional Staff in his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to Release Information

I, hereby authorize Dr. Godswill O. Okoji, torelease my medica records or incidental information that may be necessary for either medical care in processing applications for medical benefits.

Medicare/ Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Patient Signature: _____ Date: _____-_____- _____

Name: ______________________ Date Of Birth: ______________________

Pharmacy Name: ______________________ Pharmacy Phone Number: ______________

Pharmacy Address: ____

Pharmacy City, State and Zip Code: ______________________________________

Please List All Medications and Allergies

Medications	**Allergies**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

PATIENT NAME:_____ DATE:_____

DATE OF BIRTH: _____ SEX: F/M/L/G/B/T

PATIENT HEALTH QUESTIONNAIRE
CIRCLE ALL THAT APPLIES TO YOU

PAST MEDICAL HISTORY:

Hearing/ Ringing in the ear
Dizzy Spell/ Fainting Spell
Vision Problem/ Eye Pain
Nose Bleeding/ Recurrent
Sinus Trouble/ Sore Throat
Horseness/ Hayfever/ Allergies
Pneumonia/ Pleurisy
Bronchitis/ Chronic Cough/ Fever
Asthma/ Wheezing
Shortness of Breath/ Chest Pain
High Blood Pressure/ Irregular Pulse
Heart Murmur/ Palpitation
Swelling ankles/ Leg Pain
Cold Numb Feet/ Varicose Veins/ Phlebitis
Loss of Appetite/ Increased Appetite
Difficulty Swallowing/ Nutritional Problems
Heartburn/ Peptic Ulcer/ Nausea/ Vomiting
Gallbladder Disease/ Abdominal Pain
Hepatitis/ Jaundice
Diarrhea/ Constipation/ Diverticulosis
Crohn's Disease/ Blood in Stool
Hemorrhoids/ Hernia
Overactive Bladder/ Urination Leakage
Urination Urgency/ Blood in Urine
Kidney Stones/ Urinary Infection
Prostate Problems
Weight Loss/ Weight Gain
Anemia/ Easily Bruising/ Easily Fatigue
Cancer/ Diabetes/ Thyroid Disease
Seizures/ Stroke/ Tremors (hand shaking)
Numbness or Tingling sensation
Headaches/ Arthritis/ Back Pain/ Gout
Joint Injury/ Bone Fracture/ Osteoporosis
Rash/ Hives/ Psoriasis/Eczema
Sleep Disorder/ Depression/ Nervousness
Moodiness/ Suicidal Thoughts/ Memory Loss
Mental Illness/ Measles/ Mumps/ Chicken Pox
Polio/ Tuberculosis/ Herpes/ HIV/Aids/ STD
Sexual Problem
Decreased Life Enjoyment
Decreased Work Performance
Alcohol Use: _____
Cigarette Smoking: _____
Drug Use: _____

FEMALES

Menstrual Flow: Normal/Irregular
Pain/ Cramps
Days of Flow: _____
Length of Cycle: _____
Date of last period: _____
Pain or Bleeding During/ After sex
Number of Pregnancies: _____
Number of Abortions: _____
Number of Miscarriages: _____
Number of Live Births: _____
Birth Control Method: _____
Hot Flashes/ Menopause
Date of last PAP Test: _____
Normal/ Abnormal
Date of last Mammogram:_____

FAMILY MEDICAL HISTORY

Epilepsy: _____
Migraine: _____
Mental Illness: _____
Glaucoma: _____
Diabetes: _____
Thyroid Disease: _____
Hayfever: _____
Asthma: _____
Anemia: _____
Bleeds Easily: _____
Osteoporosis_____
Arthritis: _____
Heart Disease: _____
Stroke: _____
High Blood Pressure: _____
Lipid Disorder: _____
Alcoholism: _____
Cancer: _____

PAST SURGERIES

_____
_____

ULNACS Medical Care, P.C.

Godswill O. Okoji, M.D., F.A.C.P.

Form P-012 Patient Privacy Summary

Date: December 5, 2015

We are committed to preserving the privacy of your health information. In fact we are required by law to protect your medical information and to provide you with Notice describing;

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may require your written consent before we use or disclose your medical information for purpose of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent and authorization.

As our patient, you have important rights relating to inspecting and copying your medical information for other purposes without your consent or authorization.

As our patient, you have important rights to inspecting and copying your medical records that we maintain, amending or correcting that information, obtaining and accounting of our disclosure of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses of disclosure of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Private Practices which fully explains your rights and our obligations under law. We may revise our Notice from time to time. The effective date at the top left had side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current notice in effect. If you have not yet reserved a copy of our current Notice, please ask the front desk and we will provide you with a copy,

If you have any further questions, concerns or complaints about the Notice of your medical information, please contact Stacey Toy the Office Manager at 1809 Benning Road NE, Washington, DC 20002 or 3331 Toledo Terrace Suite 108, Hyattsville, MD 20782 or by telephone at (301) 408-4111.

Patient Signature: _____ **Date:** _____

ULNACS MEDICAL OFFICE POLICIES

MEDICATION REFILLS

- We DO NOT under any circumstances phone in, fax or electronically submit pain medication, anti-depressants or antibiotics to the pharmacy. You must see the Physician to receive these medications. NO EXCEPTIONS

- Medication will NOT be refilled or prescribed to any patient who has not been seen in the office by the physician WITHIN 90 DAYS. This includes refills by phone, fax or electronic submission. Please schedule and keep your appointments to prevent any delay in taking your medication. NO EXCEPTIONS

- Please bring ALL MEDICATIONS, including over the counter medication when you visit the office. If you are unable to bring your medications, please provide a CURRENT LIST, so we may better serve you in prescribing medications.

- There will be a $10.00 fee for any lost or misplaced prescriptions that need to be re-written. NO EXCEPTIONS

- If a script for PAIN MEDICATION/ANTI-DEPRESSANT/(NARCOTIC) is lost or misplaced, you may not by any means receive another script within a 30 DAY PERIOD. If a script for PAIN MEDICATION/ANTI-DEPRESSANT/(NARCOTIC) has been stolen, you must submit a POLICE REPORT to the Physician so it can be filed in your medical record. NO EXCEPTIONS

PAPER WORK/ FORMS

- We will not sign any forms for HOME HEALTH if the patient is not present in the office with his/her health aide. NO EXCEPTIONS

- If a company sends a request for medical supplies or medications and the PHYSICIAN DID NOT PRESCRIBE IT, the forms WILL NOT be signed. NO EXCEPTIONS

- If you see a SPECIALIST PROVIDER WITHOUT A REFERRAL, and WAS NOT REFERRED BY THIS PRACTICE, a referral will not be authorized nor backdated. NO EXCEPTIONS

- If you were DISCHARGED from a Hospital or Nursing Facility, you must follow up with this office (Primary Care Provider) within 7 DAYS OF YOUR DISCHARGE to ensure that you receive the proper care and referrals needed for further care.

- There will be a $25.00 FEE AND A 48 HOUR PROCESSING PERIOD before forms and letters are completed by the Physician. NO EXCEPTIONS

PLEASE SIGN BELOW TO CONFIRM THAT YOU HAVE RECEIVED THIS NOTICE

PATIENT SIGNATURE: _____ DATE: _____

STAFF SIGNATURE: _____

Patient Name: _____ Date: _____

Date of Birth: _____

Patient ADL List

1. Bathes Self (Y) (N)
2. Cleans Home Independently (Y) (N)
3. Continent of Bladder (Y) (N)
4. Cooks for Self (Y) (N)
5. Converse Meaningfully (Y) (N) (communicate with others)
6. Dresses Self (Y) (N)
7. Drive (Y) (N)
8. Feeds Self (Y) (N)
9. Finds his/ her way home independently (Y) (N)
10. Lives Independently (Y) (N)
11. Recognizes Familiar Faces (Y) (N)
12. Rides Public Transportation (Y) (N)
13. Remembers his/ her own name (Y) (N)
14. Knows the Current Date (Y) (N)