Richard Shames, MD
Independent Practitioner With Practice Management By Preventive Medical Center
(415) 388-0456.   25 Mitchell Blvd #8, San Rafael & 7840 Old Redwood Hwy, Cotati

Registration Form & Health History

(PLEASE PRINT)

Date Of Your First Appointment: ____

Your Name____
(Parent or Guardian, If Patient Is A Minor) ____________________________________

Address: ______________________________ City:______________ State:__ Zip:_____________

Cell Phone________________ Home/Work Phone: _____________ Email:_________________

Date of Birth ________ Sex: F/M. Driver's Lic#:________________Partner/Marital Status______

Who Is Your Current Primary Provider Of Medical Care? ___________________________________

How Did You Hear About Me?____
(If Referred By Someone, Their E-Mail Address/Phone) _________________________________

Emergency Contact Name & Phone ____

What Main Symptoms Bring You In Today?_______________________________________

What Medicines/Supplements Do You Take?_____________________________________

Major Illnesses Or Hospitalizations? What Year?___________________________________

List Allergies To Medicines/Foods/Environmental Exposures:_________________________

What Is Your Work?_____________________With Whom Do You Live?______________________

Do Any Of These Run In Your Family? Circle: Thyroid/Diabetes/High Blood Pressure/Cancer/
Epilepsy/Tuberculosis/Asthma/Gout/Heart Disease/Mental Illness/Obesity

Is Your Diet Generally Healthy? Y/N. Do You Crave Any Foods? (If So, What?)_______________

Any Emotions You Feel Predominately? Circle: Anger/Sadness/Fear/Mania/Anxiety/Grief

Any Difficulty With Your: Energy Level/Stress Level/Sleep/Digestion/Muscles Or Joints?

How Do You Feel About Yourself?________________ Your Life?____________________________

Any Questions You Have For The Doctor?____

Women: Are Your Periods Regular? Y/N. Do You Have Painful Periods or PMS? Y/N.
Are You Currently (Circle If So) Pregnant/Breast Feeding/ Trying To Get Pregnant?
Approx.Date Last Menstrual Period:______ Approx.Date Last Mammogram&Breast Exam:_____

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We Are Very Happy To Be Working With You! Please Review & Sign Below:

I, the undersigned, do understand that Richard Shames, MD is an independent practitioner utilizing the facilities and administrative support services of Preventive Medical Center Practice Management, a division of Preventive Medical Center ("PMC"). Richard Shames is not employed by PMC nor is he a member of PMC's medical practice staff. Decisions or recommendations regarding my care are made solely by him and are not made by PMC, its medical practitioners or its staff.

As a patient or client of the office of Richard Shames, MD, I understand that this practice is a consulting practice. I agree to have a primary doctor with whom I work in addition to the consultations with Richard Shames, MD, and that his work with me is in addition to regular medical care. I understand that he may not be available for emergencies on evenings/weekends, and if there is no time for me to be seen during regular office hours, I agree to use my primary care provider.
I, the undersigned, do understand that I am consenting to medical treatment and/or consultation, and agree to binding arbitration if any malpractice disputes arise. I understand that time has been set aside for my appointments, and if I cancel this appointment less than 24 hours in advance or do not show up I will be charged a fee of $75. (Please note that insurance companies do not pay or reimburse for missed appointments.)

I understand that all release of medical records requires a written authorization. Standard HIPAA protected health information practices are followed at these offices. I understand that aspects of my file may be shown to or described for other health care practitioners involved in my healthcare delivery. I have received a copy of the office's privacy policies or a copy has been made available to me upon my request, and I document my acknowledgement of those policies.

I, the undersigned, am financially responsible for all services provided to me. I agree that in the event of default in the payment of any amount due, and if the account should be placed in the hands of an agency or attorney for collections or legal action, I agree to pay additional charges equal to cost of collections. Additional charges may also include agency/attorney fees as well as court costs incurred and permitted by the laws governing these transactions.

Fees may apply for copying my medical records, or sending out my medical records as needed (cost ranges from $15 to $75 depending on work and number of pages). Appointments need to be scheduled for processing refills. When forms need to be filled out or letters written, the practitioner/staff will notify me whether this can be done on the phone or whether an appointment is needed; charges may be incurred depending on time taken for work to be completed.

************ Your Payment Is Due At The Time Of Service. Thank You! **************

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Patient Signature **Date**

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(Parent/Guardian Signature, For Minor Patient) Date

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