

KELLY A. SHARRAR, M.D REGISTRATION FORM

(Please Print)

Today's date:			PCP if other than above:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no. for insurance verification:	Home phone no.: ()		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ()		
Preferred Pharmacy:			How did you hear about our clinic? (check one):			
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
Other family members seen here:						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					Card on file? Yes No
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Anthem Blue Cross PPO <input type="checkbox"/> Blue Shield PPO <input type="checkbox"/> Aetna PPO <input type="checkbox"/> Cigna PPO <input type="checkbox"/> HealthNet PPO <input type="checkbox"/> Tricare Federal <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Other					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()
			Work phone no.: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kelly A. Sharrar, M.D or insurance company to release any information required to process my claims.</p>			
<hr style="width: 100%;"/> <i>Patient/Guardian signature</i>			<hr style="width: 100%;"/> <i>Date</i>

NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____ **Birth date:** ___/___/___ **Date:** ___/___/___

Referring Physician: _____ **Address:** _____

Pharmacy Name: _____ **Phone Number:** _____ - _____ - _____

Reason for today's visit: _____

Please describe this problem: _____

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE
Last Flu Shot?	Last Tetanus?	Pneumo-Vax?	Shingles Vax?

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin**? NO YES

Do you have any food, environmental, or drug allergies? NO YES (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? Never have Not Anymore(Please explain below) YES (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Married / Single / Divorced / Widowed #Children #Pregnancies

Do you drink alcohol? NO and Never have Socially Only Daily Beer/ Wine Hard Liquor

Occupation: _____ Hand Dominance: RIGHT LEFT

Other Recreational Drug Use? List type and frequency _____

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER			
FATHER			
SIBLING(S)			
OTHER HEREDITARY ILLNESS			

Patient Signature: _____ **Date:** ___/___/___

Physician Signature: _____ **Date Reviewed:** ___/___/___

HEALTH HISTORY FORM 2

Do you have or have you ever had any of the following:

Symptoms/ Illness	NO	YES, Explain	Symptoms/ Illness	NO	YES, Explain
Constitutional			Skin		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			Last Mammogram Date: ___/___/___		
Hepatitis			Changes in Moles		
HIV/ Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			Neurological		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			GENITOURINARY		
Mobility/ Joint Problems			Genital or Oral Herpes		
GASTROINTESTINAL			S.T.D.'s		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/ Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
CARDIOVASCULAR			Eyes		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/ DVT			ENT		
Blood Clots in Lungs/ Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
RESPIRATORY			PSYCHIATRIC		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/ Depression		

Please list any other conditions/ illnesses not indicated above: _____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: _____ **Date:** ___/___/___

Physician Signature: _____ **Date Reviewed:** ___/___/___

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Please write in any specific conditions/results you do not want discussed with designated individuals.

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent _____ (Patient/Representative initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic’s health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent _____ (Patient/Representative initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic’s health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page).The practice/clinic does not charge

for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I **authorize** to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.

I **authorize** to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is** _____.

-OR-

I **decline** _____ (Patient/ Representative Initials) to receive communication via text.

I **decline** _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.

I **decline** _____ (Patient/ Representative Initials) to receive communication via email.

Note: This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** _____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:
 - Name: _____ Date: _____
 - Name: _____ Date: _____
- ***I do not want*** _____ (Patient/Representative Initials) to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____

Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize _____
(Name of Patient, DOB) (Name of person or facility which has information)

to release the following health information: _____

To: _____
(Name and title or facility name to receive health information)

_____ (Street address, city, state, ZIP code) _____ (Telephone number) _____ (Fax number)

For the following purposes: _____

This authorization is in effect until _____ (date or event), when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient:	Print Name:	Date
Or Signed by Personal Representative:	_____	Date
On Behalf of	_____	
	<small>Name of Patient</small>	

KELLY A. SHARRAR, M.D.

FAMILY PHYSICIAN

Office Policy Updates – 06/03/2024

Please review these updates to our office policies. Please initial each line item and sign and date at the bottom of the page.

_____ There is a \$30.00 fee for completion of medical forms. Some forms can be dropped off, while others require an appointment to be completed. You can drop off any forms that need to be completed, and our staff will call you to set up an appointment if necessary. The fee for completion of the form must be paid when the form is dropped off.

_____ Chronic pain care is managed by a referral to a Chronic Pain Care Specialist or Clinic. Dr Sharrar does not refill or prescribe on an ongoing basis any medications that fall under The Controlled Substance Act.

_____ Patients without insurance are welcome. Estimated Payment will be collected during check in. Any additional fees will be collected at the end of the appointment. If you are unable to pay for your visit during check in, your appointment will be rescheduled.

_____ Copays are due at check in. Payment options: Cash, check, or debit/credit. Debit/credit cards are subject to a 4% surcharge paid directly to the processing company.

_____ Missed appointments or appointments canceled with less than 24 hours notice are subject to a \$150 fee.

Signature _____ Date: _____

Print name _____