

**Richard Shames, MD**  
Independent Practitioner With Practice Management By Preventive Medical Center  
(415) 388-0456. 4340 Redwood Highway, Ste. A-22, San Rafael, CA 94903

**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