Dr. Christopher M. Shaari, M.D., P.C.
20 Prospect Ave Suite 712
Hackensack, N.J. 07601
Telephone (201) 342-8060 Fax (201) 546-1536

PATIENT REGISTRATION

Patients Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

S.S.#: _____ D.O.B.: _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Employer Address: _____
Street City State Zip

Who may we thank for referring you? _____

Primary Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

FINANCIAL RESPONSIBILITY:
I am aware that my insurance carrier may not cover any or all parts of the services I have received at Christopher M. Shaari, M.D. and that I, the undersigned, do hereby guarantee payment in full to Christopher M. Shaari, M.D. of all charges rendered, or any charges exceeding insurance payments received by this office.

I have read the foregoing statement and fully understand my rights and obligations related thereto. I hereby authorize the use of this signature on all insurance submissions. I knowingly and willingly sign this statement.

Patient Signature: _____ Date: _____

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Date: _____ D.O.B.: _____

Patient's Name: _____

HEALTH HISTORY

Have you recently experienced:

Fever	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Weight Loss	☐ Yes ☐ No	Facial Pain	☐ Yes ☐ No
Night Sweats	☐ Yes ☐ No	Nosebleeds	☐ Yes ☐ No
Ringing in Ears	☐ Yes ☐ No	Difficulty Swallowing	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No	Sore Throats	☐ Yes ☐ No
Stuffy Nose	☐ Yes ☐ No	Hoarseness	☐ Yes ☐ No
Post Nasal Drip	☐ Yes ☐ No	Chills	☐ Yes ☐ No
Imbalance or Sinning Sensation	☐ Yes ☐ No		

What is the reason for your visit: _____

_____

List allergies to medicines: (please list medicine and reactions): _____

_____

List medical conditions: _____

_____

List medications you are taking: _____

_____

Do you smoke: ☐ Yes ☐ No How many years? _____

List previous surgeries: _____

_____

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Patient's Name: _____

SOCIAL HISTORY

Are you a smoker? ☐ Yes ☐ No Quit smoking? ☐ Yes ☐ No

If yes, how many Packs Per Day? _____ If you quit smoking, when was it? _____

Tobacco ☐ Yes ☐ No If yes, how much? _____

Alcohol ☐ Yes ☐ No If yes, how much? _____

Caffeine ☐ Yes ☐ No If yes, how much? _____

Exercise ☐ Yes ☐ No If yes, how much? _____

Drugs ☐ Yes ☐ No If yes, how much? _____

Living Will ☐ Yes ☐ No

Blood Transfusion? ☐ Yes ☐ No

Foreign Travel? ☐ Yes ☐ No

Power of attorney: ☐ Healthcare ☐ Finance

PERSONAL INFORMATION

Preferred language: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

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Pharmacy Information Sheet

Date: _____ D.O.B.: _____

Patient's Name: _____

Pharmacy Name: _____

Address: _____

City, State, Zip Code _____ _____ _____

Phone Number: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____

Account Number: _____

I authorize Dr. Shaari and/or his staff to release and receive information including demographics, diagnosis and/or treatment to and from other doctors, hospitals, laboratories, x-ray, CT scan, or MRI facilities. This information given is for treatment purposes only.

Signature: _____ Date: _____

I authorize Dr. Shaari and/or his staff to discuss my medical treatment to family members.

☐ Yes ☐ No

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Christopher M. Shaari M.D. PC

You May Refuse to Sign this Acknowledgment

I have read or received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____