ACCOUNT NUMBER	EDWARD J. SHARE, M.D.	DATE:

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME	SEX	BIRTHDAY
				//

PATIENT'S ADDRESS		
CITY	STATE	ZIP CODE

HOME PHONE	MOBILE PHONE	PATIENT'S SOCIAL SECURITY NUMBER

MARITAL STATUS	AGE	DRIVER LICENSE NUMBER

E-MAIL ADDRESS	BUSINESS PHONE	OCCUPATION

PATIENT'S BUSINESS NAME / ADDRESS

SPOUSE	OCCUPATION

SPOUSE'S BUSINESS NAME / ADDRESS	BUSINESS PHONE

REFERRED BY	ADDRESS

INTERNIST / PRIMARY PHYSICIAN	ADDRESS

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY	SUBSCRIBER

ADDRESS	EMPLOYER

GROUP NUMBER	I.D. NUMBER	PLAN NUMBER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	SUBSCRIBER

ADDRESS	EMPLOYER

GROUP NUMBER	I.D. NUMBER	PLAN NUMBER

NAME OF FRIEND OR RELATIVE OR GUARDIAN OR PARENT NOT LIVING WITH PATIENT

NAME	RELATIONSHIP

ADDRESS	PHONE

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Edward J. Share, M.D. to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits. I hereby grant permission to appeal Insurance Claims on my behalf. I hereby acknowledge that I have read and understood the "Notice of Privacy Practices".

COMPREHENSIVE PATIENT HISTORY

YOUR NAME _____ **DATE** _____

1. REASON YOU ARE BEING SEEN _____

2. ALLERGIES TO MEDICATION IINCLUDING TYPE OF REACTION

a. _____ c. _____
b. _____ d. _____
e. _____

3. MEDICATION YOU ARE TAKING

a. _____
b. _____
c. _____
d. _____
e. _____
f. _____

4. MEDICAL HISTORY

Heart Disease - Type _____
Mitral Valve Prolapse - Type _____
Artificial/Prosthetic Heart Valve _____
Lung Disease _____
Liver Disease / Hepatitis _____
Kidney Disease _____
Diabetes _____
Cancer _____
Seizure Disorders _____
High Blood Pressure _____
Bleeding Disorder/Tendancy _____
Orthopedic Prosthesis / Implant _____
Thyroid Disease _____
Ulcer / Reflux _____
Other Conditions (Specify) _____
Constipation _____

(Women) Number of Pregnancies: _____ Vaginal deliveries: _____ C-sections: _____

5. SURGICAL HISTORY (Please list all operations that you have had and when they were done)

a. _____
b. _____
c. _____
d. _____
e. _____
f. _____

6. FAMILY HISTORY

(Please list any family history of colon cancer or polyps, stomach cancers, or cancer in other areas of the body, Crohn's Disease or Ulcerative Colitis. Please indicate the relationship of each family member listed (mother, father, aunt, uncle, etc.).)

_____
_____
_____
_____

7. ANY ADDITIONAL INFORMATION

_____
_____
_____
_____

Edward J. Share, M.D.
Cedars-Sinai Medical Office Towers
8631 West Third Street, Suite 1015 E
Los Angeles, Ca 90048
Phone (310) 652-4472 Fax (310) 358-2266

Gastroenterology & Hepatology

Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to (*see below*).

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to (*see below*). You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact (*see below*). All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Patti Seale or Edward J. Share, M.D (310) 652-4472

8631 West Third Street, Suite 1015E, Los Angeles, Ca 90048

I hereby acknowledge that I have read and understand the "Notice of Privacy Practices".

Print Name: _____

Signature: _____

Date: _____