

PATIENT REGISTRATION FOR DR. SARITA UHR

Date _____

Patient's Name _____

Social Security Number _____ **Birthdate** _____

Home Address _____

City _____ **State** _____ **Zip Code** _____

Occupation _____

Home Phone _____

Work Phone _____

Mobile Phone _____

Driver's License Number _____

E-mail Address _____

Emergency Contact: _____

Phone Number _____

Referred By _____

I understand that I am responsible for my bill at the time of my appointment:

Signature _____

Name: _____ Date: _____

List all medications including over the counter medications and supplements:

Medication	Times Per Day	Dose in mg	Total time on medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug Allergies _____

Check all that apply:

- decreased energy
- increased energy
- sadness/depression
how long? _____
- difficulty falling asleep
- difficulty staying asleep
- decreased appetite
- increased appetite
- change in weight
how much in the last year? _____
- decrease in activity (work, social life)
- inability to enjoy family and friends
- loss of motivation at work and/or at home
- crying spells
- forgetfulness
- trouble concentrating
- decreased need for sleep
- racing thoughts
- frequent alcohol use
- marijuana, cocaine use
- stimulant use
- painkiller use
- frequent worry/anxiety
- panic attacks

Sarita Uhr, M.D.

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Dallas, Texas 75254

HIPAA Privacy Policy

Patient consent to disclosure of health information for treatment, payment, or healthcare operations per HIPAA regulations

I understand that as part of my healthcare, Dr. Sarita Uhr’s practice originates and maintains paper and electronic records describing my mental and physical health history, symptoms, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care such as those that referred you to me and those that are or will be involved in my care
- A source of information for applying my diagnosis to my bill
- A means by which a third party payor can verify that services billed were actually rendered
- A tool for routine healthcare operations

I have been provided with a “Notice of Patient Privacy Practices” that provides a more complete description of information uses and disclosures.

Signature _____

Printed Name _____ **Date** _____

I understand that I have the following rights and privileges:

- The right to review the “Notice” prior to acknowledging consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

Restrictions: I request the following restrictions to the use or disclosure of my health information:

Print the names and relationships of whom Dr. Sarita Uhr is permitted to discuss your protected health information including questions about billing (ex: spouse, relatives, doctors, therapists)

Messages and appointment reminders:

May I leave a message at your home using my name? Yes ___ No ___

May I leave a message at your work using my name? Yes ___ No ___

Messages will be of a non-sensitive nature (ex. appointment reminders).

I understand that as part of my treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and accept/decline (please circle one) the information of this consent.

Patient/Guardian Signature

Date