Cynthia Thaik, M.D., F.A.C.C.

Cardiology ▪ www.drcynthia.com

2211 W. Magnolia Blvd, Suite 140
Burbank, CA 91506
Phone: (818) 842-1410
Fax: (818) 842-1408

23501 Cinema Drive, Suite 117
Valencia, CA 91355
Phone: (661) 222-9057
Fax: (661) 222-9478

New Patient Intake Form

Date: _____

Name_____ SSN_____

Date of Birth _____ Age ____ Male ____Female ____ Marital Status _____

Address_____ City_____ State_____ Zip_____

Home Telephone _____Work Telephone _____

Email Address_____

Employer_____ Occupation _____

Emergency Contact_____Relationship_____Telephone_____

Responsible Party (if dependent)_____Relationship_____ Telephone_____

Insurance Company Name _____Telephone_____

Insurance Plan Name_____

Insurance Company Address

Street_____ City_____ State_____ Zip_____

Patient's Policy Number _____ Group Number _____

CANCELLATION POLICY:

I understand that Cynthia Thaik, MD, FACC reserves the right to charge for appointments canceled or missed without 24 hours advance notice.

SIGNED: _____

PAYMENT POLICY:

I understand that regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Cynthia Thaik, MD, FACC. I understand that Cynthia Thaik, MD, FACC will submit insurance claims, however, insurance payment for submitted claims is not guaranteed.

SIGNED: _____

Patient Name: _____ DOB: _____

CYNTHIA M. THAIK, M.D., F.A.C.C.

Patient Questionnaire:

1. Do you have high blood pressure? Y or N
2. Do you have diabetes? Y or N
3. Do you have high cholesterol? Y or N
4. Do you smoke? Y or N How much: _____
5. Are you a former smoker? Y or N How long ago: _____
6. Is there a family history of heart disease? Y or N
7. Have you ever had a heart attack? Y or N When? _____
8. Have you ever had angiogram/ angioplasty? Y or N When? _____
9. Have you had bypass or valve surgery? Y or N When? _____
10. Are you experiencing chest discomfort? Y or N How often? _____
11. Description of chest pain: _____
12. Are you experiencing heartburn, indigestion, reflux? Y or N
13. Are you getting short of breath? Y or N
14. Do you wake up at night short of breath? Y or N How often? _____
15. How many pillows do you sleep on? 1 or 2 or 3
16. Do you experience swelling of the legs? Y or N
17. Do you experience palpitations? Y or N How often? _____
18. Have you ever felt lightheaded? Y or N When? _____
19. Have you ever passed out? Y or N
20. Do you have a history of heart murmur or rheumatic fever? Y or N
21. Do you exercise regularly? Y or N Frequency: _____
22. Any difficulties with your activities? Y or N

Allergies: _____

Family history of: DIABETES/ CANCER / STROKE/
HEART DISEASE / HEART ATTACKS

Are you single, married, divorced, or widowed? _____ No. of children _____
Occupation: _____
Do you drink alcohol? Y or N How much? _____
Do you drink coffee/tea? Y or N How much? _____
Illegal Drug use? Y or N Type? _____

Past Medical History

Fever/Fatigue	Y or N
Weight Loss/ Weight Gain	Y or N
Blurred or Double Vision	Y or N
Glaucoma	Y or N
Poor Hearing	Y or N
Dry Mouth/ Sore Throat	Y or N
Chest Pains/ Chest Tightness	Y or N
Palpitations	Y or N
Heart Murmur	Y or N
Fainting	Y or N
Short of Breath	Y or N
Asthma	Y or N
COPD	Y or N
Pneumonia	Y or N
Blood In Stool	Y or N
Ulcers	Y or N
Diarrhea/Constipation	Y or N
Kidney Stones	Y or N
Bladder Infections	Y or N
Frequent Urination	Y or N
Erectile Dysfunction	Y or N
Skin Cancer	Y or N
Bruising/Rash	Y or N
Skin Infections/Ulcers	Y or N
Discoloration in Legs	Y or N
Arthritis/Gout/Sore muscles	Y or N
Anemia	Y or N
Swelling	Y or N
Leukemia	Y or N
Diabetes	Y or N
Thyroid Disease	Y or N
Cushing's Disease	Y or N
Dizziness/Headaches	Y or N
Stroke/Difficulty Walking	Y or N
Anxiety/Depression	Y or N
Hay Fever/ Sinusitis	Y or N

Other:

List of Surgeries:

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General Medical Records Release and

Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:
Patient Name: _____
Address: _____
Phone: _____
SSN: _____Date of Birth:_____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information:

All records /Laboratory/pathology records/ X-ray/radiology records
Billing records Abstract/Summary
Pharmacy/prescription records
Other (describe specifically)

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.
These records are for services provided on the following date(s):
Please send the records listed above to:

The information may be used/disclosed for each of the following purposes:

For my health care, payment/insurance, employment purposes, Other:

Cynthia Thaik, M.D., FACC, APMC
2211 W. Magnolia Blvd. Suite 140
Burbank, Ca 91506

This authorization shall expire no later than: ___/___/___ or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature for Cynthia Thaik, M.D. medical records.
I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____
Signature of patient (or patient's representative)

_____
Printed name of patient representative Representative's authority to sign for patient, (i.e parent, guardian, power of attorney for healthcare, executor)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, Patrick Hallare 2211 W. Magnolia Blvd. Suite 140 Burbank, CA 91506.

NOTICE OF PRIVACY PRACTICE

Cynthia M. Thaik M.D. F.A.C.C.

2211 W. Magnolia Blvd.#140
Burbank, CA 91505
(818) 842-1410

23501 Cinema Dr. 117
Valencia, CA 91355
(661)284-6037

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and rights regarding your medical information.
3. Follow the terms of the notice that are now in effect.

We Have The Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSUE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care provider to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.