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

New Patient Intake Form

Date: _____

Name: _____ SSN _____

Date of Birth: _____ Age: _____ Male: ☐ Female: ☐ Marital Status _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone:__ _____ Work Phone: _____ Email Address: _____

Employer: _____ ____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Responsible Party (if dependent): _____ Relationship:_____ Phone: _____

Primary Insurance Company

Insurance Name: _____ Insurance Type (ie PPO, HMO, EPO): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Policy Number: _____ Group Number: _____

Secondary Insurance Company

Insurance Name: _____ Insurance Type (ie PPO, HMO, EPO): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Policy Number: _____ Group Number: _____

Cancellation Policy:

I understand that Cynthia Thaik, MD, FACC will charge ***Fee of $35*** for appointments canceled or missed without 72 hours advance notice.

SIGNED: _____
(*Type name to sign*)

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: _____
(*Type name to sign*)

Review of Systems

Check box if applicable

Systemic Symptoms		Feeling Fatigued		Fever		Recent Weight Loss		Recent Weight Gain							
Head Symptoms		Sinus Pain		Headache											
Eye Symptoms		Worsening Vision		Floaters in visual field		Double Vision		Blurry Vision							
ENT Symptoms		Hearing Loss		Ringing in Ears		Nosebleeds		Sore Throat		Mouth Dryness					
Cardiovascular Symptoms		Chest Pain		Palpitations		Leg Pain with Exercise		Slow Heart Rate		Fast Heart Rate					
Pulmonary Symptoms		Difficulty Breathing		Shortness of Breath		Awakening at Night Short of Breath		Orthopnea		Cough		Coughing Blood		Wheezing	
GI Symptoms		No Appetite		Heartburn		Nausea		Vomiting		Bright Red Blood Per Rectum		Diarrhea		Constipation	
GU Symptoms		Blood in Urine		Change in Urinary Freq		Frequent Urination		Excess Night Urination		Urinary Urgency		Urinary Incontinence		Male Erectile Dysfunction	
Endocrine Symptoms		Flushing		Sweating Heavily at Night		Heat Intolerance		Cold Intolerance		Excessive Sweating		Feeling of Weakness		Change in Libido	
Musculoskeletal Symptoms		Back Pain		Muscle Aches		Arthralgias		Muscle Cramps		Joint Pain Localized to one or More Joints		Joint Swelling Localized to one or More Joints		Localized Joint Localized Join	
Neurological Symptoms		Dizziness		Vertigo		Fainting		Confusion		Memory Loss		Difficulty with Balance		Tingling		Numbness
Psychological		Anxiety		Depressed		Sleep									
Skin Symptoms		Localized Skin Discoloration		Rash											

Medication List: _____

Drug Allergies List: _____

List of Surgeries: _____

List of Established Medical Diagnoses: _____

Quantity of Alcohol per week: _____

Years of Smoking: _____

Relevant Family History: _____

Dr. Cynthia Thaik's Sleep Apnea Evaluation Form

The Epworth Sleepiness Scale (ESS)

Date:_____

Name: _____ DOB: _____

Email:_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 - Would never doze or sleep

1 - Slight chance of dozing or sleeping

2 - Moderate chance of dozing and sleeping

3 - High chance of dozing or sleeping

Situation	Chance of Dozing (0-3)
Sitting & reading	
Watching TV	
Sitting. inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL >>>	0

Do You Have (Check all that applies)

	High Blood Pressure		Atrial Fibrillation
	Diabetes		Lung Disease
	Heart Disease		None of the Above
	Suffered a Stroke		

Patient Acceptance of Financial Responsibility

Cynthia Thaik, M.D. will bill your insurance company (primary and secondary) for services rendered as a courtesy. Please be aware that you are ultimately responsible for all charges for services rendered. In the event services rendered are not covered by your insurance company, we will require that you remit payment to this office. Additionally, if your insurance company does not remit payment in a timely manner after rebilling the claim or appealing the claim within 60 days from the time your claim was billed, we will transfer the balance to your responsibility and require that you remit payment to this office for all outstanding insurance balances over 60 days. The outstanding balances may include, but not limited to:

- **Office visit co-payments**
- **Annual deductibles**
- **Share of costs**
- **Non-Covered services**

In addition, your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies that may be provided to you. As a courtesy, we will contact your insurance company for authorization for these services, however, it is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services. We may request your assistance in following up on our authorization requests and delayed payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services rendered, preventing delays in treatment and expedite payment. Insurance companies are more responsive when they are contacted by their policyholders, however, our billing office is always available to assist in this undertaking.

Co-payments: Co-pays are required at the time of your appointment.

Reschedule/Missed appointments: Please contact our office at least 72 hours in advance of your scheduled appointment time if you need to reschedule. **Please be advised that a $35 charge will apply to no-shows or last-minute cancellations if made within the 72-hour window**. Your cooperation in adhering to these guidelines plays a vital role in streamlining care for everyone involved.

Deductibles: If you have not met your deductible for your plan year, you will be required to pay your share of cost of your **medical services at the time of your scheduled appointment.**

Insurance Cards: You must present your insurance card at each visit to our office.

Yours in health,

Dr. Cynthia Thaik M.D.

I understand and agree that I (or the person named below who is financially responsible for me) am financially liable for all services rendered and will pay my outstanding balance promptly upon receipt of my monthly statements. I also understand that if my insurance plan does not pay Cynthia Thaik, M.O. within 60 days of services billed, the balance will be transferred to my responsibility and payment will be due at that time.

_____	_____
Patient Printed Name	Responsible Party Printed Name
_____	_____
Patient's Signature (Type.name.to.sign)	Responsible Party's Signature (Type.name.to.sign)
_____	_____
Date	Date

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

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.