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 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 72 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: _____

Check box if applicable ☑

Review of Systems

ROS										
Systemic Symptoms	Feeling Fatigued	☐ Fever	☐ Recent Weight Loss	☐ Recent Weight Gain	☐					
Head Symptoms	Sinus Pain	☐ Headache	☐							
Eye Symptoms	Worsening Vision	☐ Floaters in visual field	☐ Diplopia	☐ 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	☐ ast Heart Rate					
Pulmonary Symptoms	Difficulty Breathing	☐ Shortness of Breath	☐ Awakening at Night Short of Breath	☐ Orthopnea	☐ Cough	☐ Hemoptysis	☐ Wheezing	☐		
GI Symptoms	Anorexia	☐ Heartburn	☐ Nausea	☐ Vomitting	☐ Bright Red Blood Per Rectum	☐ Diarrhea	☐ Constipation	☐		
GU Symptoms	Hematuria	☐ Change in Urinary Frequency	☐ Polyuria	☐ Nocturia	☐ 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 Stiffness	☐		
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: _____

Holistic Healing Heart Center
BURBANK AESTHETICS MEDICAL SPA

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	_____

Do You Have (Check all that applies)

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

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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.

PLEASE SIGN ON BACK---------→

2311 W Magnolia Blvd, #140
Burbank, CA 91506

23501 Cinema Dr, #107
Valencia, CA 91355

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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.D. 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

____

Patient's Signature

____

Date

____

Responsible Party Printed Name

____

Responsible Party's Signature

____

Date

____

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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:

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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.