

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: _____

Insurance Company Name: _____ Phone: _____

Insurance Plan Name: _____

Insurance Company Address

Address: _____ 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: _____

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 Under GI	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 Joint		
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 pennit	
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)

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Atrial Fibrillation
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	None of the Above
<input type="checkbox"/>	Suffered a Stroke	<input type="checkbox"/>	



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 →



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

Responsible Party's Signature

Date

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:

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.