

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

Cardiology • [www.drcynthia.com](http://www.drcynthia.com)

10843 Magnolia Blvd, Suite 3, N Hollywood, CA 91601  
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

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

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	
<b>TOTAL &gt;&gt;&gt;</b>	

#### 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.



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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.O. within 60 days of services billed, the balance will be transferred to my responsibility and payment will be due at that time.

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Patient Printed Name

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Responsible Party Printed Name

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Patient's Signature

(Type.name.to.sign)

---

Responsible Party's Signature

(Type.name.to.sign)

---

Date

---

Date



Holistic Healing Heart  
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## **Cynthia Thaik, M.D., F.A.C.C.**

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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.