CARDIOVASCULAR MEDICAL ASSOCIATES

PATIENT REGISTRATION

NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH _____

ADDRESS _____
STREET

_____
CITY ZIP CODE

TELEPHONE NUMBER ( ) -

OCCUPATION _____

ETHNICITY _____ PRIMARY LANGUAGE _____

SOCIAL SECURITY # - -

PRIMARY CARE PHYSICIAN _____

PRIMARY CARE TELEPHONE _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____

EMERGENCY CONTACT PHONE NUMBER _____

RELATIONSHIP _____

FINANCIAL RESPONSIBILITY AGREEMENT

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE SAID MEDICAL INFORMATION REQUESTED BY INSURANCE COMPANIES WITH WHOM I HAVE COVERAGE OR ANY PUBLIC AGENCY AND IT'S AGENTS TO DETERMINE BENEFITS FOR SERVICE PROVIDED OR BENEFITS FOR RELATED SERVICE.

ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT OF THE INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN FOR ANY SERVICES RENDERED THAT ARE NOT PAID DIRECTLY BY ME. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO CARDIOVASCULAR MEDICAL ASSOCIATES (CVMA) FOR CHARGES NOT COVERED BY THIS AGREEMENT. IT IS MY RESPONSIBILITY TO NOTIFY CVMA WITH ANY CHANGES TO MY INSURANCE(S)**. I AUTHORIZE REFUND OR OVERPAID INSURANCE BENEFITS WHERE MY COVERAGE IS SUBJECT TO COORDINATION OF BENEFITS. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY'S FEES.

AUTHORIZATION TO TREAT: I CONSENT TO AN EXAMINATION, TREATMENT, AND PROCEDURES WHICH MAY BE PERFORMED DURING OFFICE VISITS INCLUDING EMERGENCY TREATMENT CONSIDERED NECESSARY BY THE PHYSICIAN/NURSE PRACTITIONER.

Signature _____ **Date** _____

CARDIOVASCULAR MEDICAL ASSOCIATES

Cardiovascular Disease- Internal Medicine

(562) 869-1511 * Fax (562) 869-0771

Kaushal R. Tamboli, MD F.A.C.C.
Paul H. Yoshino, MD
Paiboon Mahaisavariya, MD F.A.C.C.
Jocelyn D. Sampedro, MSN NP

Downey Regional Medical Plaza
11480 Brookshire Ave #307
Downey Ca, 90241

St Francis Medical Plaza
3628 E. Imperial Blvd #201
Lynwood Ca, 90262

NAME/NOMBRE_____ **DOB/Fecha dnacimiento**_____

Allergies/Alergias_____

History of past Illness (Have you had?)/Enfermedades pasadas (Ha tenido)

Congestive heart failure/insuficiencia cardíaca	**NO**	**YES/SI**	When/Cuando_____
Heart attack/Infarto de Corazón	**NO**	**YES/SI**	When/Cuando_____
Heart disease/enfermedad del Corazón	**NO**	**YES/SI**	When/Cuando_____
High Blood Pressure/Hipertensión	**NO**	**YES/SI**	When/Cuando_____
High Cholesterol/ Colesterol alto	**NO**	**YES/SI**	When/Cuando_____
Diabetes	**NO**	**YES/SI**	When/Cuando_____
Strokes/Embolia	**NO**	**YES/SI**	When/Cuando_____
Rheumatic Fever/Fiebre Reumática	**NO**	**YES/SI**	When/Cuando_____
Anemia/Anemia	**NO**	**YES/SI**	When/Cuando_____
Cancer	**NO**	**YES/SI**	When/Cuando_____
Psychiatric Illness/Problemas Psychiátricos	**NO**	**YES/SI**	When/Cuando_____
Muscles and Bones/Músculos o Huesos	**NO**	**YES/SI**	When/Cuando_____
Problems with Liver/Problemas con Hígado	**NO**	**YES/SI**	When/Cuando_____
Problems with Kidneys/Problemas con Riñones	**NO**	**YES/SI**	When/Cuando_____
Asthmas/Asma	**NO**	**YES/SI**	When/Cuando_____
Peptic Ulcer/Ulceras	**NO**	**YES/SI**	When/Cuando_____
Serious Disease/Enfermadades Graves	**NO**	**YES/SI**	When/Cuando_____

Vascular

Pain in legs at rest or with ambulation/ Dolor en las piernas	**NO**	**YES/SI**	When/Cuando_____
Do you have any discomfort or aching in the muscles of your legs when you walk that is relieved by rest? *¿Siente alguna molestia o dolor en los músculos de las piernas cuando camina y se alivia al descansar?*	**NO**	**YES/SI**	When/Cuando _____
Do your legs ever feel fatigued or heavy when walking or active? *¿Alguna vez siente las piernas fatigadas o pesadas cuando camina o está en actividad?*	**NO**	**YES/SI**	When/Cuando _____
Do you ever need to stop and rest when walking or have difficulty keeping up with others? *¿Alguna vez se detiene a descansar cuando camina o tiene dificultad para seguir el ritmo de los demás?*	**NO**	**YES/SI**	When/Cuando _____
Do your feet or toes bother you at night? *¿La mayoría de las noches le molesta una sensación de quemazón dolor o frío en los pies o dedos de los pies?*	**NO**	**YES/SI**	When/Cuando _____
Have you noticed a difference in color or temperature in your feet? *¿Ha notado cambios en el color o la temperatura de los pies?*	**NO**	**YES/SI**	When/Cuando _____

Have you noticed that wounds take longer to heal? **NO** **YES/SI** When/Cuando _____
¿Ha observado que las heridas tardan mucho en sanar?

Would you have difficulty doing any of the following because of leg fatigue, weakness, or discomfort?
¿Tendría dificultad para hacer alguna de los siguientes actividades debido a fatiga, debilidad o molestias en las piernas?

	NO DIFFICULTY	**SOME DIFFICULTY**	**UNABLE**
Walking one block/*Caminar una cuadra*	1	2	3
Climbing one flight of stairs?/*Subir un tramo de escaleras*	1	2	3
Walking at an increased pace?/*Caminar a ritmo rapido*	1	2	3

Do you have a history of, or take medication for any of the following? (please check)
- [ ] Diabetes or "borderline" diabetes
- [ ] Smoking or history of smoking or tobacco use

Ever Hospitalized/Ha sido Hospitalizado?
Explain/Explique_____

Ever had Surgery ?/Ha Tenido Cirugías?
Explain/Explique_____

Social History/Historia Social

	Never/Nunca	**Yes/Si**	**How much/Cuanto**
Alcoholic beverages/Bebidas alcoholicas			
Tobacco or Cigarettes/Tabaco o Cigarillos			
.Exercise/ejercicio			
.Recreational drugs/Consume drogas			

Have you ever had/Ha tenido

Stress test / examen de stress	**NO**	**YES/SI**	When/Cuando_____
Echocardiogram (ultrasonido del corazón)	**NO**	**YES/SI**	When/Cuando_____
Cardiac Catherization / caterización cardíaca	**NO**	**YES/SI**	When/Cuando_____
Coronary Angioplasty/stent / angioplastía coronaria	**NO**	**YES/SI**	When/Cuando_____
Coronary Bypass Surgery – cirugía coronaria	**NO**	**YES/SI**	When/Cuando_____
Valve Surgery - cirugía de la válvula	**NO**	**YES/SI**	When/Cuando_____
An Electrophysiology Study (EPS)	**NO**	**YES/SI**	When/Cuando_____
Pacemaker or Difibrillator - Marcapaso	**NO**	**YES/SI**	When/Cuando _____

Family History/Historia Familia Has anyone in your family ever had?/Ha habido en su familia

Heart Trouble/Enfermedad del Corazón	**NO**	**YES/SI**	When/Cuando_____
Stroke/Embolio	**NO**	**YES/SI**	When/Cuando_____
Diabetes	**NO**	**YES/SI**	When/Cuando_____

Patient Signature:_____ Date:_____

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FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:_____ Date of Birth:_____Date of Visit: _____

Cardiovascular Medical Associates will collect co-pay for office consultations and Follow-up visits at the time of the visit. Some insurance companies require co-pay for procedures such as but not limited to Echocardiograms, Stress Echo's, and Myocardial Perfusion Study. Co-pays for office procedures will be billed to patients.

I understand and ***agree*** it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of-pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorize the insurance provider to pay Cardiovascular Medical Associates for services rendered.

I hereby authorize payment of benefits to be made by me. I understand that I am financially responsible to Cardiovascular Medical Associates for charges not covered by this agreement. ***It is my responsibility to notify Cardiovascular Medical Associates with any changes to my insurance (s).***

I authorize refund for overpaid insurance benefits where my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

If current insurance coverage cannot be verified prior to each appointment, payment may be due at the time of service. I will be responsible and billed for charges incurred.

Signature _____ **Date** _____

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NOTICE OF PRIVACY PRACTIVE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third-party payers**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I acknowledge that I have been informed and offered a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organizations has the right to change its Notice of Privacy Practices from time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature _____ **Date** _____