Hope Cardiovascular Center

27450 Ynez Rd, STE 109, Temecula, CA 92591 P: (951) 587-0070
26960 Cherry Hills Blvd, STE C, Sun City, CA 92586 P: (951) 301-0300

PATIENT INFORMATION

DATE: _____

PATIENT NAME (Last, First, MI): _____

DOB: _____ SSN: _____ EMAIL:_____

HOME ADDRESS:_____ CITY: _____

STATE: _____ZIP: _____

MAILING ADDRESS (if different from above):_____

HOME PHONE: _____ CELL PHONE:_____

PLEASE CIRCLE ONE: 1. MALE / FEMALE 2. MARITAL STATUS: Single Married Divorced Widowed

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SUBSCRIBER: _____

ID NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____SUBSCRIBER: _____

ID NUMBER: _____ GROUP NUMBER: _____

IF INSURANCE GUARANTOR IS SPOUSE OR PARENT / LEGAL GUARDIAN, PLEASE PROVIDE THEIR INFO BELOW:

SPOUSE NAME: _____ DOB: _____PHONE: _____

PARENT OR LEGAL GUARDIAN NAME:_____PHONE: _____

I have authorized Hope Cardiovascular center to perform medical services necessary during my treatment. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance, non-covered service, or if my insurance company pays me directly. I also authorize Hope Cardiovascular Center or my insurance company to release any information required to process my claims.

EMERGENCY CONTACT

NAME: _____ HOME PHONE: _____

RELATIONSHIP: _____ WORK PHONE: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Under Federal HIPAA Regulations, my protected Health Information may be used by Hope Cardiovascular Center for the purpose of treatment, payment, and operations only. In addition to this, I hereby give my authorization to release my personal information (written and verbal) to the following person/organization. I understand that this authorization is in effect indefinitely unless revoked in writing by myself or legal representative.

PERSON TO WHOM INFORMATION MAY BE DISCLOSED: _____RELATIONSHIP: _____

PATIENT SIGNATURE: _____DATE: _____

Hope Cardiovascular Center

27450 Ynez Rd, STE 109, Temecula, CA 92591 P: (951) 587-0070
26960 Cherry Hills Blvd, STE C, Sun City, CA 92586 P: (951) 301-0300

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that is related to your past, present or future physical or mental condition and related health care services.

I. Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We may disclose your protected health information to a physician who interprets special diagnostic studies. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for diagnostic testing or a hospital admission may require that your relevant protected health information be disclosed to the health plan to obtain approval on your behalf.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and training of employees, students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your appointment time and time of your arrival. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors and Organ Donation; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; and Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

II. Use & Disclosures of Protected Health Information Based on Your Written Authorization:

You may be asked to sign a written authorization form, permitting one or more of the following uses and disclosures for fund raising activities, for request by others, for research purposes, for uses by the hospital, or for disclosure of sensitive patient information. Any authorization you may sign will include: (1) the type of information, (2) who will use or disclose the information, (3) who will receive the information, (4) the purpose, (5) an expiration date, (6) the date you signed, or (7) the date your personal representative signed on your behalf. You are not required to identify the purpose of any authorization if you do not want to.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or other physician's practice has acted in reliance on the use or disclosure indicated in the authorization.

III. Your Rights:

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information, such as if it is copyright protected, or the access is reasonably likely to result in the disclosure of the source of confidential information or to cause death or serious bodily injury. In some of these cases, you have a right to a review of the decision denying access.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request unless you are requesting disclosure to a health plan for purposes of payment or healthcare operations (as defined above) and you have paid in full for the services. If the physician believes it is in your best interest to permit, use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. For example, you could ask us not to leave a message or to only call you on your cell phone.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE AND WILL INFORM YOU BY MAIL OF ANY CHANGES. You then have the right to object or withdraw as provided in this notice.

IV. Complaints:

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PATIENT SIGNATURE: _____DATE: _____

Hope Cardiovascular Center

27450 Ynez Rd, STE 109, Temecula, CA 92591 P: (951) 587-0070
26960 Cherry Hills Blvd, STE C, Sun City, CA 92586 P: (951) 301-0300

Patient History Form

Name: _____ Date of Birth: _____

Today's Date: _____

Who is the physician sending you to us? Dr. _____

What is the reason for today's visit? _____

TELL US ABOUT YOURSELF:

Single _____ Married _____ Divorced _____ Widowed _____

Children? _____ Are they healthy? ____

Employment:

Status: Full time____ Part time____ Retired____ Disabled____ Homemaker____

Occupation: Type of work/job: _____

Habits: Do you smoke? No____ Yes____ If yes, how many packs per day? ____

If you have quit, how long ago? ____

Do you use alcohol? No____ Yes____ If yes, how often do you drink? ____

If you have quit, how long ago? ____

Do you use drugs? No ____ Yes ____

MEDICAL HISTORY:

Please list any surgeries (operations), reason for the surgery and date of surgery:

_____

_____

FAMILY HISTORY:

Family Member	Deceased?	Age	Conditions?
Father:			
Mother:			
Brothers or Sisters:			

Hope Cardiovascular Center

27450 Ynez Rd, STE 109, Temecula, CA 92591 P: (951) 587-0070
26960 Cherry Hills Blvd, STE C, Sun City, CA 92586 P: (951) 301-0300

Prescription medication

Medication Name	Dose	Frequency

Over-the-counter medications such as aspirin, ibuprofen, vitamins, or laxatives

Medication Name	Dose	Frequency

Allergies or adverse drug reactions? Please list drug and type of reaction.

Are you allergic to iodine or shellfish? Yes ____ No ____

Hope Cardiovascular Center

27450 Ynez Rd, STE 109, Temecula, CA 92591 P: (951) 587-0070
26960 Cherry Hills Blvd, STE C, Sun City, CA 92586 P: (951) 301-0300

SYSTEM REVIEW

Cardiovascular

- ❑ Aneurysm
- ❑ Blocked arteries
- ❑ Blood clots
- ❑ Chest pain
- ❑ Congestive heart failure
- ❑ Fainting
- ❑ Heart valve problems
- ❑ High cholesterol
- ❑ History of angina or heart attack
- ❑ History of coronary artery disease
- ❑ History of high blood pressure
- ❑ History of irregular heart beats
- ❑ History of poor circulation
- ❑ Leg cramps
- ❑ Leg swelling
- ❑ Murmur
- ❑ Pacemaker
- ❑ Palpitations
- ❑ Rheumatic fever

Cancer

- ❑ Cysts
- ❑ Enlarged lymph nodes
- ❑ Hodgkin's
- ❑ Leukemia
- ❑ Tumors

Eyes, ears, nose, throat

- ❑ Blurred vision
- ❑ History of glaucoma or cataracts
- ❑ Other change in vision
- ❑ Loss of hearing
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Hoarseness

Gastrointestinal

- ❑ Poor appetite
- ❑ Abdominal pain
- ❑ GERD
- ❑ Trouble swallowing
- ❑ Diarrhea
- ❑ Constipation
- ❑ Change in stools
- ❑ Nausea or vomiting
- ❑ Rectal bleeding
- ❑ History of liver disease

Genitourinary

- ❑ Blood in urine
- ❑ Frequent or painful urination
- ❑ Kidney problems
- ❑ Renal stones

Endocrine

- ❑ Adrenal disorder
- ❑ Excessive thirst
- ❑ Change in tolerance to hot or cold
- ❑ Gout
- ❑ History of diabetes
- ❑ History of thyroid disease

Immune

- ❑ Lupus
- ❑ Raynaud's
- ❑ AIDS (Acquired Immune Deficiency Syndrome)
- ❑ ARC (AIDS Related Complex)

Neurologic

- ❑ History of stroke
- ❑ Blackouts or loss of consciousness
- ❑ Migraine headaches

Muscle/Joint/Bone

- ❑ Swelling of ankles or legs Pain, weakness or numbness in:
- ❑ Arms or hands
- ❑ Back or hips
- ❑ Legs or feet
- ❑ Neck or shoulders

Pulmonary/Lungs

- ❑ Shortness of breath
- ❑ Persistent cough
- ❑ Coughing up blood
- ❑ Asthma or wheezing

Skin

- ❑ Itching
- ❑ Easy bruising

Hope Cardiovascular Center

27450 Ynez Rd, STE 109, Temecula, CA 92591 P: (951) 587-0070
26960 Cherry Hills Blvd, STE C, Sun City, CA 92586 P: (951) 301-0300

Men Only

- O Prostate problems
- O Impotence

Women Only

- O Abnormal PAP smear
- O Bleeding between periods
- O Date of lasts mammogram ____
- O Breast biopsies
- O Breast masses
- O Pregnant Yes _____ No_____
- O Expected delivery date: –

Procedures

- O Electrocardiogram
- O Treadmill stress test
- O Holter monitor
- O Echocardiogram
- O Cardiac catheterization
- O Coronary angiogram
- O Coronary balloon angioplasty
- O Stent procedures
- O Coronary bypass surgery
- O Heart valve surgery

Thank you for answering these questions completely. These details help us to understand your heart situation better.

I attest that all information given above is complete and accurate to the best of my knowledge.

_____ _____

Signature Date

Hope Cardiovascular Center

27450 Ynez Rd, STE 109, Temecula, CA 92591 P: (951) 587-0070
26960 Cherry Hills Blvd, STE C, Sun City, CA 92586 P: (951) 301-0300

RECORDS RELEASE

DATE: _____

PATIENT: _____

BIRTH DATE: _____

THIS IS TO REQUEST AND AUTHORIZE:

FROM: _____
(Name of Doctor/Facility you are authorizing to release information.)

_____
Street City State and Zip

To release and/or disclose the medical information indicated below to the following healthcare provider/entity: ***This authorization is limited for the purpose of follow up treatment.***

TO: _____
(Name of Doctor/Facility to whom you want information sent.)

_____
Street City State and Zip

CHECK RECORDS TO BE RELEASED:

____ All Medical Records ____ X-Rays ____ Lab Work
____ Operative Reports ____ Discharge Summary ____ H & P
____ Other: (Fill in information you want released.)

This authorization shall become effective immediately and shall remain in effect until _____ or unless revoked in writing by myself at any time prior to the release of information. This information has been disclosed from records whose confidentiality is protected by Federal Law. I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law. I further understand that I have the right to receive a copy of this authorization upon my request.

SIGNED: _____

ADDRESS: _____