SYNERGY CT SURGERY PARTNERSHIP
Nan Wang, M.D. / Shanka Biswas, M.D. / Hossein Shayan, M.D.
901 San Bernardino Rd., Suite #102 - Upland, CA 91786
Phone: (909) 579-6721 Fax: (909) 579-6737

Date:_____ **Home Phone:**_____ **Cell Phone:**_____

NAME:_____ **Birthdate:**_____ **Age:**____
(Last) (First) (Middle)

ADDRESS:_____ **SS/HIC/Patient ID#:**_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

SEX: ☐ **M** ☐ **F** **Race/Ethnicity:**_____ **Primary Language:**_____

☐ **Married** ☐ **Widowed** ☐ **Single** ☐ **Separated** ☐ **Divorced** ☐ **Minor** ☐ **Partner**_____

Patient Employer/School:_____ **Occupation**_____

Employer/School Address:_____ **Employer/School Phone:**_____

Whom may we thank for referring you?_____

In case of an emergency, who should be notified?_____ **Phone:**_____

Relationship to patient:_____

PERSON RESPONSIBLE FOR ACCOUNT:_____

SOCIAL SECURITY:_____ **BIRTHDATE:**_____

OCCUPATION:_____ **EMPLOYER:**_____

EMPLOYER'S ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

PRIMARY CARE PHYSICIAN:_____ **CARDIOLOGIST:**_____

PULMOLOGIST:_____ **OTHER MD:**_____

INSURANCE COMPANY:

1._____ **2.**_____

ALLERGIES:_____

PHARMACY NAME & PHONE #:_____

My signature below indicates approval to release information for insurance purposes and also authorizes insurance benefits to be paid directly to Synergy CT Surgery Partnership. I am financially responsible for all services not covered by Insurance.

_____ _____
Signature of patient or guardian Date

Revised: 12-12-2011

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act (HIPAA), in order for your physician or staff of the practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____I do not authorize the Practice to release any or all information concerning my medical care to any individuals except as set forth.

_____I authorize the Practice to verbally release any or all information concerning my medical care to the following individuals.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Patient Name & Date of Birth Phone Number

_____ _____
Patient Signature Date

SYNERGY CT SURGERY PARTNERSHIP

Cardiovascular and Thoracic Surgery

Nan Wang MD, FACS, FACC, FACCP
Hossein Shayan MD, FRCSC
Shanka Biswas MD, FACS
Rohit Trivedi MD, FACS

901 San Bernardino Road Suite 102 Upland, CA 91786
(Office) 909-579-6721 (Fax) 909-579-6737

Notice of Privacy Practices & Patient Acknowledgement

Patient Name:_____ Date of Birth:_____

I have received this practice's notice of privacy practices written in plain language. The notice provides in detail the uses and discloses of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide, by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment and health care operations.
- A description of each of the other purposed for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of used and disclosures that are prohibited or materially limited by law.
- A description of other uses, and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that nor retaliatory actions will be used against me if the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a request restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of privacy practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of privacy practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of privacy practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by personal representative of patient):_____

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Cardiovascular and Thoracic Surgery

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Authorization for Release of Protected Health Information

Please release my medical records from the following:

Individual / Agency Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Send Records to:

Individual/ Agency Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Information to be released: Dates Desired:

☐ Inpatient
- ☐ Discharge Summary
- ☐ Standard Clinical Pertinent Documents
- ☐ Other:_____

☐ Outpatient
- ☐ Specific Clinic_____
- ☐ Ancillary Tests
- ☐ Other (Please Specify) _____

Records released are authorized for the following purpose:

☐ Continued Care ☐ Determination of Disability ☐ Personal Use
☐ Attorney/Legal ☐ Insurance ☐ Other (Specify):_____

I understand authorizing the disclosure of the information above is voluntary. I need not sign this form in order to receive treatment. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date _____. If I fail to specify an expiration date, this authorization will expire 90 days from the date of signature.

I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department.

Patient Name: _____ SSN: _____
Birth Date:_____ Phone Number:_____

_____ _____
Signature of Patient or Legal Representative Date / Time

_____ _____
Relationship to Patient (If unable by Legal Representative) Witness

Patient is unable to sign because:_____

0044A

CURRENT HEALTH PROBLEMS

Do you currently have or have you recently had the following?
(Circle "Y" or "N", no response if uncertain)

General

Y | N Chronic sense of fatigue
Y | N Poor appetite
Y | N Weight loss not due to dieting
Y | N Fever or night sweats
Y | N Anemia

Skin

Y | N Skin rash
Y | N Itching
Y | N New growth or changing mole

Eyes / Ears / Nose / Throat

Y | N Trouble seeing, uncorrected by eye glasses
Y | N Hearing loss
Y | N Nosebleed
Y | N Infected teeth or gums

Cardio-Respiratory System

Y | N Frequent coughing
Y | N Coughing up blood
Y | N Wheezing
Y | N Stop breathing while asleep
Y | N Shortness of breath
Y | N Chest or arm pain or pressure
Y | N Racing heart rhythm
Y | N Irregular heart rhythm
Y | N Fainting or near fainting
Y | N Swelling of ankles
Y | N Discomfort in calf of leg triggered by walking

Digestive System

Y | N Abdominal pain or distress
Y | N Frequent heartburn
Y | N Difficult or painful swallowing
Y | N Bleeding from stomach / bowel
Y | N Nausea or vomiting
Y | N Change in bowel function
Y | N Frequent diarrhea
Y | N Frequent constipation

Urinary System

Y | N Blood in urine
Y | N Pain on urination
Y | N Difficulty passing urine
Y | N Frequent urination at night

Musculo-Skeletal System

Y | N Hernia
Y | N Muscle weakness or aching
Y | N Painful or stiff joints
Y | N Back or neck trouble

Nervous System / Psychological

Y | N Severe headaches
Y | N One sided weakness / numbness
Y | N Transient: Confusion or impairment of vision or of speech
Y | N Memory loss
Y | N Numbness or burning of feet
Y | N Often feel anxious
Y | N Often discouraged or depressed

Breasts

Y | N Lumps
Y | N Discharge

GYN-OB

Y | N Are you possibly pregnant?
Y | N Heavy menstrual bleeding ?
Y | N Are you post menopause?
Y | N Abnormal bleeding?

NUMBER OF: Pregnancies _____
Miscarriages _____ Births _____

SURGERY / PROCEDURES

Indicate surgery or procedures undergone by placing a check mark. Specify year(s) surgery or procedure took place.

Year(s)

☐ Heart angiogram
☐ Angioplasty or stent
☐ Coronary bypass
☐ Heart valve surgery
☐ Appendix
☐ Gallbladder surgery
☐ Hysterectomy
☐ Mastectomy
☐ Prostate surgery
☐ Varicose vein surgery
☐ Other surgery:

_____
_____
_____
_____

Have you had complications from surgery or other procedures? Y | N
if "Y" explain:

_____
_____

ALLERGIES:

PENICILLIN Y | N
SULFA Y | N
OTHER ALLERGIES Y | N
SPECIFY:

_____
_____

PLEASE LIST MEDICATIONS: Include nonprescription medications & dosages if known.

PLEASE COMPLETE BOTH SIDES OF THIS SHEET

1 _____ 6 _____
2 _____ 7 _____
3 _____ 8 _____
4 _____ 9 _____
5 _____ 10 _____

Synergy Cardiothoracic Surgery Medical Corp.
OUTPATIENT RECORD
CardioThoracic Surgery
901 San Bernardino Rd., Suite #102
Upland, CA 91786

PATIENT IDENTIFICATION
Name:
Birth Date:
MR No.:

MEDICAL HISTORY (circle "Y" or "N", no response if uncertain):

Have you ever had?	Year first occurred
Y | N High blood pressure	
Y | N Diabetes	
Y | N High cholesterol	
Y | N Heart attack	
Y | N Cardiac arrest	
Y | N Heart failure	
Y | N Atrial fibrillation	
Y | N Rheumatic fever	
Y | N Aneurysm of aorta	
Y | N Phlebitis (clotted vein)	
Y | N Blood clot in lung	
Y | N Stroke	
Y | N Bleeding tendency	
Y | N Bleeding of stomach or of bowel	

Have you ever had?	Year first occurred
Y | N Ulcer of stomach or duodenum	
Y | N Ulcerative colitis or Chron's disease	
Y | N Diabetic eye problem	
Y | N Blood transfusion	
Y | N Asthma	
Y | N Convulsions / seizures	
Y | N Autoimmune disorder	
Y | N Gout	
Y | N Radiation therapy	
Y | N Chemotherapy	
Y | N Cancer (state type):	
_____	
_____	

Have you ever had?	Year first occurred
Y | N Gallbladder trouble	
Y | N Pancreatitis	
Y | N Hepatitis / liver disease	
Y | N HIV infection	
Y | N Kidney disease	
Y | N Kidney stone	
Y | N Nervous breakdown	
Y | N Osteoporosis	
Y | N Polio	
Y | N Thyroid trouble	
Y | N Tuberculosis	
Y | N Other serious illnesses or injuries (specify):	
_____	
_____	

SOCIAL HISTORY

Age _____ Sex _____ Birthplace _____

Nationality _____ Religion _____

Occupations _____

Marital status _____ Health of spouse _____

Number of living children _____

In what town do you live? _____

With whom do you live? Alone _____ Spouse _____

Children _____ Parent(s) _____ Other _____

Have you used any of the following? Circle "Y" or "N".

Intravenous drugs Y | N Cocaine Y | N

Amphetamines Y | N Marijuana Y | N

Smoking history (place check-mark):

☐ Never smoked

☐ Former smoker, specify when stopped _____

☐ Current smoker

Alcohol and tobacco, average amount per day:

Alcohol amount and type _____

Cigarettes, packs / day _____

Other tobacco (type) _____

Caffeine containing beverages, cups or servings per day:

Coffee _____ Tea _____ Soft Drinks _____

Has your use of alcohol ever been of concern to you? Y | N

FAMILY HISTORY

Your father (place check mark): ☐ Living ☐ Deceased.

If deceased: age at death ____ cause of death _____

Your mother (place check mark): ☐ Living ☐ Deceased.

If deceased: age at death ____ cause of death _____

HAS ANY BLOOD RELATIVE HAD THESE PROBLEMS? (Circle "Y" or "N", no response if uncertain)	HOW PERSON(S) RELATED TO YOU
Y | N Diabetes	
Y | N High blood pressure	
Y | N Coronary disease or heart attack	
Y | N Other heart problem	
Y | N Heart trouble before age of 60 years	
Y | N Stroke	
Y | N Kidney disease	
Y | N Colon cancer	
Y | N Breast cancer	

Identify other medical disorders which may run in your family:

_____

NAME: _____

DATE: _____

PLEASE COMPETE BOTH SIDES OF THIS SHEET

FOR PHYSICIAN USE I reviewed the information on both sides of this sheet.

Date: _____ Signature: _____

Synergy Cardiothoracic Surgery Medical Corp.
OUTPATIENT RECORD
CardioThoracic Surgery
901 San Bernardino Rd., Suite #102
Upland, CA 91786

PATIENT IDENTIFICATION

Name:

Birth Date:

MR No.: