PEDIATRIC CARDIOLOGY
MEDICAL ASSOCIATES
OF SOUTHERN CALIFORNIA

Timothy W. Casarez, MD., FACC
David A. Ferry, MD., FACC
Nancy Kim, MD., FACC
Frederic Leong, MD., FACC
Jeffrey A. Wong, MD., FACC

FAX COVER LETTER

Welcome to our cardiology practice! In order to save time, please fill out our new patient registration forms and fax them to our office or bring them with you to your child's appointment. For your convenience, you may use this page as the fax cover letter and please do not hesitate to call our office with any questions.

DATE: _____

TO: **PEDIATRIC CARDIOLOGY MEDICAL ASSOCIATES**

FAX #'S: **ENCINO, SANTA CLARITA, LANCASTER:**
Fax (818) 784-1531 • Tel (818) 784-6269

THOUSAND OAKS:
Fax (805) 497-0864 • Tel (805) 497-7214

FROM: _____

PATIENT: _____

TOTAL NUMBER OF PAGES INCLUDING COVER SHEET: _____

STATEMENT OF CONFIDENTIALITY:
THE DOCUMENT ACCOMPANING THIS COPY TRANSMISSION CONTAINS CONFIDENTIAL INFORMATION BELONGING TO THE SENDER WHICH IS LEGALLY PRIVILEGED. THE INFORMATION IS INTENED ONLY FOR THE USE OF THE INDIVIDUAL OR INTENDED NAME ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION, OR TAKING OF ANY ACTION IN RELIANCE ON THE CONTENTS OF THIS COPIED INFO IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS IN ERROR PLEASE CALL US AT 818-784-6269

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- How this office will use and disclose your protected health information.
- Your privacy rights with regard to your protected health information.
- This office's obligations concerning the use and disclosure of your protected health information.

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

Patient or guardian name (print): _____

Patient or guardian signature: _____ Date: _____

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PATIENT MEDICAL HISTORY

Patient's Name: _____

Your Name: _____ Relationship to Patient: _____

Birth History:

Yes No Was the patient born prematurely?
Yes No Were there any complications during the pregnancy?
Yes No Did the patient have any complications following the delivery?
Yes No Was the patient born by Cesarean section?
Birth weight of child: pounds ounces

Has the patient ever had any of the following? If yes, please explain.

Yes No Heart murmur
Yes No Chest Pain
Yes No Fainting
Yes No Palpitations/rapid heart beats
Yes No Shortness of breath
Yes No High blood pressure
Yes No Weight Loss
Yes No Fatigue
Yes No Pneumonia
Yes No Asthma
Yes No Allergies
Yes No Digestive/eating problem
Yes No Eye disease/eye glasses
Yes No Ear/nose/throat problem
Yes No Skin problem
Yes No Neurologic disorder/ Seizures
Yes No ADD/ADHD
Yes No Autism Spectrum Disorder
Yes No Psychiatric Disorder
Yes No Developmental Delays/Learning Disability
Yes No Hormone problems/Diabetes
Yes No Blood problem/Anemia
Yes No Cancer
Yes No Smoking
Yes No Hospital admission or surgery
Yes No Allergies to medications
Yes No Does your child take any medications

Has anyone in your family had the following? If yes, please explain.

Yes No Child born with a heart problem
Yes No Heart attack or stroke before age 50 years
Yes No High Cholesterol or Blood Pressure
Yes No Sudden cardiac death or cardiomyopathy
Yes No Heart arrhythmia/Pacemaker.