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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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Cardiology Medical Associates of Southern California (PCMA) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to PCMA's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PCMA reserves the right to revise its Notice of Privacy Practices at PCMA any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Cristina Mercado, PCMA Privacy Officer at 5400 Balboa Blvd, Suite 202, Encino, CA 91316.

With my consent, PCMA may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and insurance items; and in reference to my clinical care, including laboratory results, among others.

With my consent, PCMA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential."

With my consent, PCMA may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that PCMA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to PCMA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, PCMA may decline to provide treatment to me.

_____

Patient's Name

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name Legal Guardian

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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.