Dear New Patient:

We are sending you a medical questionnaire to complete at home. Please bring it with you to your appointment date.

PLEASE BRING ALL YOUR CURRENT MEDICATIONS WITH YOU TO YOUR APPOINTMENT.

IT IS VERY IMPORTANT that we have pertinent records from your referring physician including laboratory reports, EKG’s Treadmill Tests, Holter Monitors, or Echocardiogram copies. You may bring copies with you or request that they be forwarded directly to this office. (Enclosed is an Authorization to Release Records form you may send to your referring physician)

We do insurance billing for all Medicare, PPO, HMO and Managed Care patients. We are happy to bill group insurance for other patients, providing the visit is paid at the time of service and current billing information is supplied. Please bring your insurance cards so they may be copied for your file, do not bring electronic cards. Deductible and co-payments are to be paid at the time of service in keeping with your insurance coverage requirements.

Our schedule is very heavily booked at all times. It is important that you have all the forms completed and arrive 30 minutes prior to your appointment. Please notify us right away if you are unable to keep this appointment. Should you have any questions I can be reached at (714) 564-3300

Sincerely,

Tina
New Patient Coordinator
Orange County Heart Institute and Research Center New Patient Form

Date:________________________  Date of Birth:________________________

Name________________________ Personal History

Present Illness (in your own words)

________________________________________________________________________

Please list all past illnesses, hospitalizations and injuries (date included):

________________________________________________________________________

None ☐

________________________________________________________________________

Please list all your medications, dosage and number of times taken daily:

________________________________________________________________________

None ☐

________________________________________________________________________

Primary Pharmacy:________________________ Phone: (____)__________________ Fax: (____)__________________

Street________________________ State________________________ Zip Code________________________

Please list any medications and/or substances to which you are allergic; give the type of reactions (e.g.: hives, wheezing, nausea, etc that you have experienced)

________________________________________________________________________

None ☐
Orange County Heart Institute and Research Center New Patient Form

<table>
<thead>
<tr>
<th>Family History</th>
<th>If Living</th>
<th>If Deceased</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>AGE</td>
<td>HEALTH (Poor, Good, Excellent)</td>
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<tr>
<td>FATHER</td>
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<td></td>
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<tr>
<td>MOTHER</td>
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<tr>
<td>Husband/Wife</td>
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<tr>
<td>BROTHERS &amp; SISTERS</td>
<td>Sex</td>
<td>AGE</td>
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<td>SONS &amp; DAUGHTERS</td>
<td>SEX</td>
<td>AGE</td>
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</tbody>
</table>

Do you know of any blood relative who has or had: (circle and give relationship)

- Stroke
- Epilepsy
- Heart Attack
- Cancer
- Colitis
- Stomach Ulcer
- High Blood Pressure
- Migraines
- Kidney Disease
- Tuberculosis
- Asthma
- Gout
- Diabetes
- Hay Fever
- Arthritis
- Leukemia
- Bleeding disorders
- Mental Illness
- Hyperlipidemia
- High Cholesterol
- Nervous Breakdown
- Rheumatic Heart
- Congenital Heart Disease
- Suicide

Do you smoke? Cigarettes _____ Pipe _____ Cigars _____ Year Started? ________________

Were you exposed to second hand smoke in the past? Yes No

How many caffeinated beverages do you drink per day? Coffee _____ Tea _____ Soft Drinks _____

Do you drink alcoholic beverages? Occasionally (1-3 per month) _____ Regularly (1-2 per week) _____

Daily (1-3 per daily) _____ Continually (4+ per day) _____ Other ________________

Do you currently use illicit or illegal drug use? Yes No

Communication Channels
Orange County Heart Institute and Research Center New Patient Form

Patient Medical Records Release Please Expedite

Appointment Date________________________________________ Time________

PATIENT INFORMATION

PATIENT’S NAME_________________________________________ DATE OF BIRTH

PATIENT RELEASE OF INFORMATION

I, the undersigned, hereby authorize:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

to release to Orange County Heart Institute and Research Center any and all medical records and

Specifically ________________________________________________________________

Date(s) / Year(s) of Service__________________________________________________

Please forward all records to the following office location:

☐ Orange Office, 1140 W La Veta Ave Ste 640 Orange CA 92868
   Fax (949) 231-5115 Attention: Saul

☐ Bristol Office, 2621 So. Bristol St Ste 204 Santa Ana CA 92704
   Fax (714) 545-6724

☐ Irvine Office, 4050 Barranca Pkwy Ste 110 Irvine Ca 92604
   Fax (949) 552-2759

USE OF INFORMATION:

The information supplied pursuant to this authorization is for diagnosis and treatment purposes and is restricted to
the use of the physicians of the Orange County Heart Institute and Research Center.

No further authorization is made than is specifically indicated in this form and an additional written consent must
be obtained for any new or different use of the information than is authorized herein, or for the transfer of this
information to another person or entity.

________________________________________________________________________

Patient

Signature________________________________________ Date:____________________

Witness_________________________________________ Date:____________________