EnteBella MEDICAL

PATIENT'S NAME: _____DATE OF BIRTH:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ SOCIAL SECURITY #: _____

EMAIL ADDRESS: _____

WOULD YOU LIKE TO RECEIVE EMAILS REGARDING MONTHLY SPECIALS? _____ YES _____ NO

MARITAL STATUS: S M D W IF MARRIED SPOUSE'S NAME: _____

PRIMARY CARE PHYSICAN: _____ PHONE: _____

REFERRING PHYSICAN: _____ PHONE: _____

PRIMARY INSURANCE: _____

ID #_____ GROUP: _____

SUBSCRIBER NAME: _____EMPLOYER NAME:_____

SECONDARY INSURANCE: _____

ID #_____ GROUP: _____

EMERGENCY CONTACT:

NAME: _____ PHONE: _____

RELATION TO PATIENT:_____

I certify that I have read and agree to Cardiothoracic & Vascular Surgeons, LTD/Dr. Pang's payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I authorize Dr. Pang to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances, within 90 days of notification of the amount due, will result in submission to an outside collection agency. A $35.00 returned check fee will be charged for checks returned due to insufficient funds.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Cardiothoracic & Vascular Surgeons, LTD/Dr. Pang. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. I authorize Dr. Pang to request any medical records or information that may be necessary for my medical care.

PATIENT'S SIGNATURE: _____ DATE: _____

Patient History Form

Date_____

This is a confidential record and is maintained in our office. The information will not be released without your permission to do so.

Name: _____ **Date of Birth**:_____

Ethnicity: _____ **Occupation**:_____

Are you allergic to any medicine? Please list medicine and reaction_____
Do you have a living will or advance directive? **Yes No**

Past Medical History

Have **YOU** or anyone in your family (parents, grandparents or siblings) had any of the following? Please list whom.

Yes No Heart disease, stroke, heart attack before age 60 _____
Yes No High blood pressure _____
Yes No Diabetes _____
Yes No Colon Cancer_____
Yes No Breast Cancer _____

Do you have any other medical problems? _____
_____

List medications, vitamins, hormones and/or any supplements that you are currently taking
_____ _____
_____ _____
_____ _____

Circle any surgeries you may have had: Appendix C-Sections Gallbladder Heart
Hysterectomy Knee or Hip Replacement Tonsils/Adenoid

List any other surgeries:_____

List any other hospitalizations and reason:_____

Social History

Do you currently smoke? **Y N** How long have you smoked?_____ When did you quit?_____

Do you drink alcohol? **Y N** How much?_____ How often?_____

Do you currently use recreational drugs? **Y N** In past? **Y N**

Women only: First day of last menstrual period? _____
Number of pregnancies_____ Live births_____ Miscarriages _____
Date of last mammogram _____ Pap smear _____DEXA SCAN_____

Review of Systems

Do you *REPEATEDLY* have any of the following issues related to the following systems? Please circle

Constitutional
Fever
Chills
Unexplained Weight Loss
Unexplained Weight Gain
Other_____

Eyes
Blurred Vision
Double Vision
Pain
Other_____

Allergic/Immunologic
Seasonal Allergies
Food Allergies_____
Other_____

Neurologic
Tremors
Headaches
Numbness
Tingling Peripheral
Neuropathy
Other_____

Endocrine
Excessive Thirst
Too Hot/Cold
Tired/Sluggish
Other_____

Gastrointestinal
Abdominal Pain
Nausea/Vomiting
Diarrhea
Constipation
Heart burn
Hepatitis B C
Other_____

Integumentary
Skin Rash
Acne
Persistent Itch
Other_____

Musculoskeletal
Joint Pain
Neck Pain
Back Pain
Other_____

Ear/Nose/Throat/Mouth
Ear Infection
Sore Throat
Sinus Issues
Other_____

Genitourinary
Painful Urination
Frequency of Urination
Losing Urine with cough or sneeze
Sexual Preference M F Both
Other_____

Respiratory
Constant cough
Shortness of Breath
Wheezing
Other_____

Hematologic/Lymphatic
Swollen Glands
Blood Clotting Disorder

Psychological
Are you general satisfied with your life? Y N
Do you feel depressed? Y N
Difficulty sleeping? Y N
Current stressors:_____

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about our patients may be used and disclosed. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. (HIPAA). This notice is effective as of 4/14/03 and will remain in effect until we replace it.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or a law enforcement official.
8. For Workers Compensation and similar programs.
9. To remind you of needed appointments in the near future by way of a mailed postcard.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in the patient's care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please ask the front desk receptionist.
4. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable laws.

If you have any questions regarding this notice please **let us know!!!**

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices for Cardiothoracic & Vascular Surgeons, LTD (EnteBella Medical).

Signature of Patient _____

Name of Patient_____ Date_____

Revised August 2018

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

[ ] Home Telephone _____
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only
[ ] Ok to fax to this number

[ ] Written Communication
[ ] Ok to mail to my home address
[ ] Ok to mail to my work/office address

[ ] Work Telephone_____
[ ] Ok to leave message with detailed information
[ ] Leave message with call back number only

[ ] Other _____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

DATE	Disclosed to who Address or Fax number		By whom Disclosed	