Los Alamitos
CARDIOVASCULAR
3771 Katella Avenue, Suite 300, Los Alamitos, California 90720, Pharmacy Line 562.430.7533 x183, Fax 562.430.8055

❑ Alan M. Gold, M.D. *No. AG7559719* ❑ Timothy O'Neill, M.D. *No. BO2077623* ❑ Bret Witter, M.D. *No. BW3294840*
❑ Stuart Fischer, M.D. *No. AF9325778* ❑ Steven Forman, M.D. *No. BF4128802* ❑ Ramandeep K. Brar, M.D. *No. BB7519979*

NAME _____ DATE _____

Past Medical History _____

Medical Problems: _____

_____

_____

Operations: _____

_____

_____

Allergies to Medicines: _____

_____

_____

Medications You Are Now Taking: _____

_____

_____

Social History: _____

Smoke _____

Alcohol _____

Occupation _____

Change in weight recently _____

Medical History in Family: _____

Father _____

Mother _____

Brothers _____

Sisters _____

Grandparents _____

Others _____

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PLEASE MARK THE APPROPRIATE BOX IF YOU HAVE THESE SYMPTOMS

	NEVER	SOMETIMES	FREQUENTLY
1. CHEST PAIN	☐	☐	☐
SHORTNESS OF BREATH AT REST	☐	☐	☐
2. WITH EXERCISE	☐	☐	☐
3. ANKLE SWELLING	☐	☐	☐
4. PALPITATION	☐	☐	☐
5. SKIPPED HEARTBEATS	☐	☐	☐
6. COUGH	☐	☐	☐
7. PHLEGM (MUCOUS)	☐	☐	☐
8. COUGH BLOOD	☐	☐	☐
9. INDIGESTION	☐	☐	☐
10. VOMITING	☐	☐	☐
11. DIARRHEA	☐	☐	☐
12. CONSTIPATION	☐	☐	☐
13. BLOOD IN STOOL	☐	☐	☐
14. BLACK STOOL	☐	☐	☐
15. PAINFUL OR BLOODY URINE	☐	☐	☐
16. VAGINAL BLEED (FEMALES)	☐	☐	☐
17. SLOW URINARY STREAM	☐	☐	☐
18. ARTHRITIS	☐	☐	☐
19. PARALYSIS	☐	☐	☐
20. TINGLING	☐	☐	☐
21. LEG CRAMPS WITH WALKING	☐	☐	☐
22. SEIZURES	☐	☐	☐
23. BLEEDING	☐	☐	☐

NAME _____ DATE _____
(SIGNATURE)

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NEW HIPAA PRIVACY REGULATIONS

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the office of Los Alamitos Cardiovascular Group, Inc. (Alan Gold, M.D., Stuart Fischer, M.D., Timothy O'Neill, M.D., Steven Forman, M.D., Bret Witter, M.D., Ramandeep Brar, M.D.) will not reveal to anybody personal information about you or your family member (i.e. name, address, social security number as well as other health information) without your permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation or fund raising.

It is, however, understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, billing (paper and wire), includes fax transmissions, insurance company follow-up and interaction with billing services relating to patient care
- Hospital workers, nurses, aids and medical records department
- Emergency officials, Paramedics, fire personnel, emergency room physicians, nurses or technicians. Personal religious designate.
- Our office staff
- Pharmacists, drug program personnel/workers
- Completions of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

My signature below authorizes the release of any necessary information listed above.

_____	_____	_____
Patient's Name	Signature of Patient/Guardian	Date