Truong Duong, MD
Cardiology
Electrophysiology

PATIENT INFORMATION (COMPLETE IN FULL)

NAME: DATE OF BIRTH:

ADDRESS: AGE:

MARITAL STATUS:

EMPLOYMENT: BEST PHONE #:

SOCIAL SECURITY #: DRIVER LICENSE #:

PRIMARY INSURANCE: GROUP #:

ADDRESS: ID #:

ADDITIONAL INSURANCE: DEDUCTIBLE:

IF HMO, LIST YOUR MEDICAL GROUP:

GUARDIAN INFORMATION (COMPLETE IN FULL)

MOTHER/FATHER/OTHER (CIRCLE ONE):

ADDRESS: BEST PHONE #:

SOCIAL SECURITY #:

EMPLOYMENT: DRIVER LICENSE #:

INSURANCE CARRIER:

ADDRESS: GROUP #:

ID#:

ADDITIONAL INFORMATION REQUIRED (COMPLETE IN FULL)

REFERRING PHYSICIAN: PHONE #:

ADDRESS:

EMERGENCY CONTACT: PHONE #:

ADDRESS:

FOR MINORS, WHO WILL BE BRINGING THE PATIENT FOR OFFICE VISITS?

Systems Review:

• Constitutional Symptom:

Good general health lately	yes	no
Recent weight change	yes	no
Fever	yes	no
Fatigue	yes	no
Headaches	yes	no

• Eyes

Eye disease or injury	yes	no
Wear glasses/contact lens	yes	no
Blurred or double vision	yes	no
Glaucoma	yes	no

• Ears/Nose/Mouth/Throat

Hearing loss or ringing in the ears	yes	no
Nose bleeds	yes	no
Mouth sores	yes	no
Bleeding gums	yes	no

• Cardiovascular

Heart trouble	yes	no
Chest pain or angina pectoris	yes	no
Palpitation	yes	no
Shortness of breath with walking or lying	yes	no
lying flat		
Swelling of feet, ankles, or hands	yes	no

• Respiratory

Chronic or frequent coughs	yes	no
Spitting up blood	yes	no
Shortness of breath	yes	no
Asthma or wheezing	yes	no

• Gastrointestinal

Loss of appetite	yes	no
Change of bowel movements	yes	no
Nausea or vomiting	yes	no
Frequent diarrhea	yes	no
Painful bowel movements or	yes	no
constipation		
Rectal bleeding or blood in stool	yes	no
Abdominal pain or heartburn	yes	no
Peptic ulcer (stomach or duodenal)	yes	no

• Genitourinary

Frequent urination	yes	no
Burning or painful urination	yes	no
Blood in urine	yes	no

• Musculoskeletal

Joint pain	yes	no
Joint stiffness or swelling	yes	no
Weakness of muscles or joints	yes	no
Muscle pain or cramps	yes	no
Back pain	yes	no
Cold extremities	yes	no
Difficulty in walking	yes	no

• Integumentary (skin, breast)

Rash or itching	yes	no
Change in skin color	yes	no
Change in hair or nails	yes	no
Varicose veins	yes	no

• Neurological

Frequent or recurring headaches	yes	no
Lightheaded or dizzy	yes	no
Convulsions or seizures	yes	no
Numbness or tingling sensations	yes	no
Tremors	yes	no
Paralysis	yes	no
Stroke	yes	no
Head injury	yes	no

• Psychiatric

Memory loss or confusion	yes	no
Nervousness	yes	no
Depression	yes	no
Insomnia	yes	no

• Endocrine

Glandular or hormone problem	yes	no
Thyroid disease	yes	no
Diabetes	yes	no
Excessive thirst or urination	yes	no
Heat or cold intolerance	yes	no
Skin becoming dryer	yes	no
Change in hat or glove size	yes	no

• Hematologic/Lymphatic

Slow to heal after cuts	yes	no
Bleeding or bruising tendency	yes	no
Anemia	yes	no
Phlebitis	yes	no
Past transfusion	yes	no

• Allergic/Immunologic

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	yes	no
Morphine, Demerol, or other narcotic	yes	no
Novocaine or other anesthetics	yes	no
Aspirin or other pain remedies	yes	no
Tetanus antitoxin or other serums	yes	no
Iodine, methiolate or other antiseptic	yes	no

Other drugs/medications

Known food allergies

This is to the best of my ability:

Patient Signature/Date

Physician Signature/Date

New Patient Information Sheet

In an effort to better serve you, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name: First: DOB: Age: Gender: M/F

Referred By:

Chief Complaint:

ALLERGIES (TO MEDICATIONS):

MEDICAL HISTORY:

Baseline Height:_____ Baseline Weight:_____

Patient medical history:

Diabetes	no	yes
Hypertension	no	yes
Cancer	no	yes
Stroke	no	yes
Heart trouble	no	yes
Arthritis/gout	no	yes
Convulsions	no	yes
Bleeding tendency	no	yes
Acute infections	no	yes
Venereal disease	no	yes
Hereditary defect	no	yes

Previous Hospitalization/Surgeries/Serious Injuries When?

Medications (Indicate strength & dosage):

1) 6)

2) 7)

3) 8)

4) 9)

5) 10)

Patient social history:

Marital status: Single Married Separated Divorced Widowed

Use of alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Previously, but quit _____ years ago Current packs/day_____

Use of drugs: Never Type/Frequency:_____

Excessive exposure at home or work to: Fumes Dust Solvents Air-borne particles Noise

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings:			

CONSENT TO TREAT

The undersigned consents to the treatment which may be performed on an outpatient basis, which include medical and other procedures and any emergency treatment or services.

_____	_____	_____
Patient Signatures	Responsible Party Signature	Date

INSURANCE AUTHORIZATION AND ASSIGNMENT

(PLEASE READ)

I hereby authorize Dr. Truong Duong to furnish information to insurance carriers concerning my illness and treatment. I authorize Dr. Duong to use and disclose my Protected Health Information (PHI) for the purposes of treatment, payment, and healthcare operations. I hereby assign to Dr. Duong all payments for medical services rendered to me or my dependents. I have received a copy and reviewed Dr. Duong's Notice of Privacy Practices (NPP) and understand it provides more detailed information how Dr. Duong may use and disclose PHI. I understand that Dr. Duong has the right to apply the payment to any outstanding balances I may have with Dr. Duong. I understand and agree that any credit granted to me shall be paid promptly in accordance with the terms and agreements. In addition, Dr. Duong may add one and one half percent (1-1 ½ percent) per month to any balance owed, and in the event of default I agree to pay reasonable collection charges and/or attorney fees.

_____	_____	_____
Patient Signatures	Responsible Party Signature	Date

FEES ASSESSED TO PATIENTS

APPOINTMENTS:
Our practice is dedicated to quality care and exceptional service. We work very hard to schedule appointments that accommodate the busy scheduling needs of all of our patients. Broken and missed appointments create scheduling problems for other patients as well as the practice. Therefore, we require a minimum of 24 hour notice for any changes so that we may accommodate another patient. A charge of $35.00 will be applied for broken and missed appointments without advance notification. This fee will not be covered by insurance, and thus will be billed to the patient directly.

FORMS:
Due to the considerable time involved in the completion of forms, our practice will charge a $50.00 forms fee. This fee will be billed to the patients directly-not to insurance companies. Payment is due when the form is dropped off. Request will be processed within 15 working days.

MEDICAL RECORDS:
Upon written consent of the patients' authorization to release medical records, a base fee of $15.00 will be assessed with $0.25 per page to be copied. If medical records are to be faxed, only the base fee will apply. All payment is due prior to the records to be released. Request will be processed within 10 working days, unless in the event of a medical emergency, records will be provided as soon as possible. All copied medical records will not be mailed and will have to be picked up by only the patient or authorized requesting party.

Patient Name/Guardian_____

Patient Signature/Guardian_____

Date: _____

ADVANCE HEALTHCARE DIRECTIVE

Dear Patient,

As your physician, we are required to ask any patient over the age of 18, if they have an existing Advance Healthcare Directive so that we can incorporate the information into your medical record. You are not required to give us this information, but we are required to ask. Please complete this form and return to the receptionist.

PATIENT NAME:_____ SS#:_____

PATIENT SIGNATURE:_____ DATE:_____

I decline to answer these questions YES_____ NO_____

Do you have an Advance Healthcare Directive? YES_____ NO_____

If yes, please indicate which type of directive:

Durable Power of Attorney for Healthcare _____

California Natural Death Act _____

Living Healthcare Will _____

Other:_____ _____

Will you bring us a copy of your directive? YES_____ NO_____

Internal Office Use Only

Type of Healthcare directive received: Date Received:_____

Durable Power of Attorney for Healthcare _____

California Natural Death Act _____

Living Healthcare Will _____

Other:_____ _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance & Accountability Act Of 1996 "HIPPA", I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

PATIENT NAME:_____

RELATIONSHIP TO PATIENT:_____

SIGNATURE:_____DATE:_____