



**FULLERTON CARDIOVASCULAR MEDICAL GROUP**  
**2240 N. Harbor Blvd. #200 Fullerton, CA 92835-2635**  
**(714) 870-4665**

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**PATIENT REGISTRATION**

Patient: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: M  W  S  D

Social Security Number: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Name: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Emergency Phone: (     ) \_\_\_\_\_ Primary Care MD Phone: (     ) \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Social Security Number: \_\_\_\_\_

Spouse's DOB: \_\_\_\_\_ Spouse's Employer's Name: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: Private  Medicare  HMO  Worker's Comp   
Cash

Insured Name: \_\_\_\_\_ Self  Spouse  Other

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Secondary Insurance: Private  Medicare  HMO

Insured Name: \_\_\_\_\_ Self  Spouse  Other

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Worker's Comp: \_\_\_\_\_ Date of Injury: \_\_\_\_\_



**CLINICAL DATA** GENERAL

Date:

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ S M DIVORCED

ADDRESS: \_\_\_\_\_

OCCUPATION \_\_\_\_\_ REF. BY \_\_\_\_\_

Writing Hand (Left or Right): \_\_\_\_\_

For which symptom(s) were you referred? \_\_\_\_\_

When did symptom(s) start? \_\_\_\_\_

What type(s) of exercise do you do, and how often? \_\_\_\_\_

Have you had any of the following performed?

Exercise ( Stress/treadmill) test: \_\_\_\_\_

24-hour ECG monitor: \_\_\_\_\_

Echocardiogram: \_\_\_\_\_

Heart catheterization ( angiogram ) \_\_\_\_\_

Have you ever had:  Rheumatic Fever  Scarlet Fever  Diptheria  Murmur

Enlarged Heart  Heart Attack  Heart Rhythm Problem

Please list ALL medications and doses: \_\_\_\_\_ Allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list ALL prior surgeries/hospitalizations (childhood included) with approximate date(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any health problems of family members ( if deceased, please detail age and cause):

Father: \_\_\_\_\_

Mother : \_\_\_\_\_

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_

Education: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

HISTORY FORM

PATIENT NAME:

MAIN PROBLEMS: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

- Decreased Hearing
- Ringing in Ear
- Ear Infections - Frequent
- Dizzy Spells
- Fainting Spells
- Failing Vision
- Eye Pain
- Double or Blurred Vision
- Eye Infections
- Nose Bleeds - recurrent
- Sinus Trouble
- Sore Throats
- Hayfever/Allergies
- Hoarseness - prolonged
- Pneumonia/Pleurisy
- Bronchitis/Chronic Cough
- Asthma/Wheezing
- Shortness of Breath:
  - on exertion
  - lying flat
- Chest Pain
- High Blood Pressure
- Heart Murmur
- Swollen Ankles
- Irregular Pulse
- Palpitations
- Leg Pain - when walking
- Varicose Veins/Phlebitis
- Loss of Appetite - recent
- Difficulty Swallowing
- Heartburn Peptic Ulcer
- Persistent Nausea/Vomiting
- Abdominal Pain - chronic
- Gall Bladder trouble
- Jaundice/Hepatitis
- Change in Bowel Habits
- Diarrhea Constipation
- Diverticulosis
- Crohn's/Colitis
- Bloody or Tarry Stools
- Hemorrhoids
- Hernia
- Urine Infections - frequent
- Blood in Urine Kidney Stones
- Urination - Overnight > than twice
  - Painful
  - Loss of Control
  - Decrease in Force/Flow
- Venereal Disease
- Urethral Discharge
- Chronic Fatigue
- Weight Loss - recent
- Anemia Bruise Easily
- Cancer
- Diabetes
- Thyroid Disease
- Seizures Stroke
- Tremor/Hands Shaking
- Muscle Weakness
- Numbness/Tingling Sensations
- Headaches - frequent
- Arthritis/Rheumatism
- Back Pain - recurrent
- Bone Fracture/Joing Injury
- Gout
- Osteoporosis
- Foot Pain Cold Numb Feet
- Rashes Hives
- Psoriasis Eczema
- Sleeping - difficulty
- Depression
- Nervousness
- Memory Loss
- Moodiness - excessive
- Mental Illness Phobias
- Rheumatic Fever Scarlet Fever
- Chicken Pox Polio Mumps
- Measles German Measles
- Tuberculosis Herpes
- Alcohol \_\_\_\_\_ oz per week
- Smoking \_\_\_\_\_ cig/day
  - # yrs \_\_\_\_\_ yr quit



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:**

I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services.

**ASSIGNMENT OF BENEFITS:**

I hereby authorize payment of benefits be made directly to FULLERTON CARDIOVASCULAR MEDICAL GROUP for services provided to me by FULLERTON CARDIOVASCULAR MEDICAL GROUP and that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

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**Signature of Patient**

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**Date**



## **Acknowledgement of Receipt of Notice of Privacy Practices**

**Fullerton Cardiovascular Medical Group, Inc.  
2240 N. Harbor Blvd., Ste. 200  
Fullerton, CA 92835-2605**

**Susan M. Sheraga, Administrator, Privacy Officer  
(714) 870-4665**

**I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.**

**I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:**

**Signed: \_\_\_\_\_ Date: \_\_\_\_\_**

**Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_**

**If not signed by the patient, please indicate:**

**Relationship:**

**parent or guardian of minor patient**

**guardian or conservator of an incompetent patient**

**beneficiary or personal representative of deceased patient**

**Name of Patient: \_\_\_\_\_**



**Fullerton Cardiovascular**  
Medical Group, Inc.

2240 N. Harbor Blvd., Suite 200, Fullerton, CA 92835-2605  
telephone 714.870.4665 facsimile 714.870.1582  
doctors@fullertonheart.com www.fullertonheart.com

**REQUEST FOR MEDICAL RECORDS**

DATE: \_\_\_\_\_

PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

DAY PHONE: \_\_\_\_\_ CELL OR EVENING PHONE: \_\_\_\_\_

**PLEASE SEND RECORDS TO:**

**FULLERTON CARDIOVASCULAR MEDICAL GROUP, INC.  
2240 N. HARBOR BLVD., STE. 200  
FULLERTON, CA 92835-2605**

I request this release of records as the:  patient  next of kin  conservator of the person

I understand that I have a right to receive a copy of this authorization upon my request.

I authorize you, your agent, or legal representative to release and disclose as requested the following medical information to **Fullerton Cardiovascular Medical Group:**

- All medical information, including but not limited to records pertaining to examinations, treatments, consultations, reports, history, admissions and discharge reports, treatment records, laboratory finding, EKG's and any other pertinent cardiac work-up results.
- Only the following types of medical information

\_\_\_\_\_

This Authorization shall remain valid unless revoked but **will expire in one year** after signing.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

**For Office Use Only**

Date records requested: \_\_\_\_\_

By: \_\_\_\_\_

Records requested from: \_\_\_\_\_

Faxed to and fax # \_\_\_\_\_