INLAND CARDIOLOGY MEDICAL ASSOCIATES

B. Don Ahn, M.D., F.A.C.C. **Padmini P. Tummala, M.D., F.A.C.C.**

Thank you for calling Inland Cardiology. Your appointment is:

Date: _____

Time: _____ ****Please arrive 15 minutes prior to scheduled appointment time.**

Provider: _____

Enclosed is a patient information form that you may complete at your convenience. Please bring it with you to your appointment. Also be sure to bring:

1. Your **insurance identification** card.
2. **Referral** or **authorization** from your primary physician.
3. List of all **medications** that you are currently taking including dosage and frequency. Please bring medication bottles.
4. A copy of any **lab tests** done in the last 1-2 months. Your primary physician can fax them to us at (909) 920-0406 if necessary.
5. **PLEASE BE PREPARED TO PAY YOUR COPAY AT THE TIME OF THE VISIT. WE ONLY ACCEPT CASH OR CHECKS. NO ATM OR CREDIT CARDS.**

If you are unable to keep your appointment please give us 24 hour notification.

Our office is located on the south corner at the intersection of Alta and Foothill Boulevard across from Del Taco. (See map) Please plan on arriving 15 minutes prior to your appointment in order to process your paper work. Please feel free to contact us at (909) 982-6500 if we can be of further assistance.

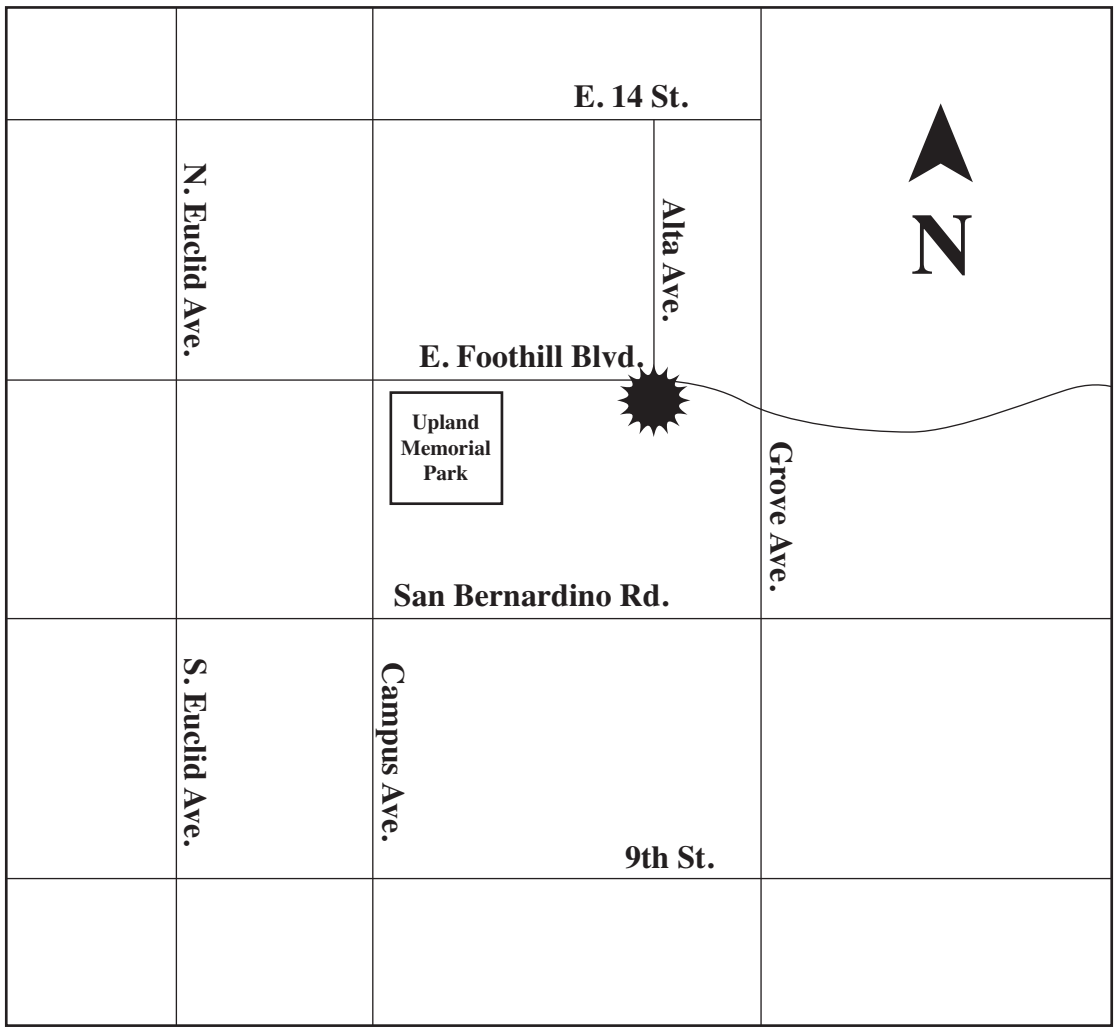
We are very happy to have you as a new patient and look forward to meeting you at your scheduled time.

Sincerely,

The Staff of Inland Cardiology

Inland Cardiology

1382 E. Foothill Blvd.
Upland, CA. 91786
(909) 982-6500



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NAME: _____ SEX: M/F AGE: _____
last first MI

SOCIAL SECURITY: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: Home_____ Work_____

CELL PHONE: _____

OCCUPATION: _____ EMPLOYER: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

MARITAL STATUS: Single / Married / Divorced / Widow / Child

SPOUSE'S NAME: _____TELEPHONE: _____

EMERGENCY CONTACT: _____
(Family or friend outside of home)

RELATIONSHIP: _____ TELEPHONE: _____

PRIMARY CARE PHYSICIAN: _____

INSURANCE COMPANY: 1. _____
2. _____

PHARMACY: _____ TELEPHONE: _____

My signature below indicates approval to release information for insurance purposes and also authorizes insurance benefits to be paid directly to Inland Cardiology Medical Associates. I am financially responsible for all services not covered by insurance.

_____ _____
Signature of patient or guardian Date

PATIENT NAME: _____

HEIGHT: _____ WEIGHT: _____

MEDICAL HISTORY

Check all that apply:

☐Chest pain/angina	☐Congenital heart disease	☐Kidney disease
☐Heart failure	☐Fatigue	☐Liver disease
☐Heart attack	☐Anemia	☐Thyroid disease
☐Heart murmur	☐Shortness of breath	☐Diabetes
☐Stroke/TIAs	☐Asthma	☐Stomach ulcer
☐High blood pressure	☐COPD	☐Leg pain when walking
☐High cholesterol	☐Sexual dysfunction	☐Scarlet fever
☐ Irregular heart beat	☐ Dizziness/fainting	☐Rheumatic fever

FAMILY HISTORY

		Heart attack	Heart bypass surgery	Heart failure	Cardiomyopathy	Pacemaker
Adopted/Unknown ☐						
Father:	alive/deceased ____age	☐age____	☐age____	☐	☐	☐
Mother:	alive/deceased ____age	☐age____	☐age____	☐	☐	☐
Siblings:						
S/B	alive/deceased ____age	☐age____	☐age____	☐	☐	☐
S/B	alive/deceased ____age	☐age____	☐age____	☐	☐	☐
S/B	alive/deceased ____age	☐age____	☐age____	☐	☐	☐
S/B	alive/deceased ____age	☐age____	☐age____	☐	☐	☐

SURGERY

Type	Date	Type	Date

HABITS

Smoke: Y/N Packs daily_____ How long_____ Quit date_____

Alcohol: Y/N Type_____ Amount per week_____

Coffee: Y/N Cups daily_____ Other caffeine:_____ Amount_____/day

Current exercise routine: Type _____ Frequency_____

Are you stressed? Y/N

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PATIENT NAME:_____BIRTHDATE:_____

DRUG ALLERGIES

_____

_____

_____

CURRENT MEDICATIONS

NAME	DOSE	FREQUENCY

Inland Medical Plaza • 1382 E. Foothill Blvd. • Upland, CA 91786 • TEL: (909) 982-6500 • FAX: (909) 920-0406

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize INLAND CARDIOLOGY to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third party administrator, or managed care company.

_____ _____

Patient Signature *Date*

_____ _____

Printed Name *Date of Birth*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implement through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize the Practice to release any or all information concerning my medical care to any individual except as set forth above.

_____ I authorize the Practice to verbally release any or all information concerning my medical care to the following individuals:

_____ _____

Name *Relationship to Patient*

_____ _____

Name *Relationship to Patient*

_____ _____

Patient Signature *Date*

_____ _____

Witness *Date*

INLAND CARDIOLOGY MEDICAL ASSOCIATES

B. Don Ahn, M.D., F.A.C.C. Padmini P. Tummala, M.D., F.A.C.C.

INLAND CARDIOLOGY
PRIVACY POLICY

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At INLAND CARDIOLOGY the privacy of our patients has always been and will continue to be extremely important. We maintain a long standing policy of protecting your personal health information. Legislation passed by Congress as part of the Health Insurance Portability and Accountability Act (HIPAA) creates national standards to protect your personal health information.

We have initiated a Privacy Policy Statement. This policy lets you know exactly what is happening with your personal health information and it lets you control the sharing of this information.

If you would like a copy of our Privacy Policy Statement please let us know and we will be happy to provide one for you.

If you have any questions or concerns about your personal health information we will be happy to answer them for you.

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AS A COURTESY TO OUR OTHER PATIENTS THAT HAVE SCHEDULED APPOINTMENTS, WE REQUEST THAT YOU ARRIVE ON TIME FOR YOUR SCHEDULED VISIT.

ALL PAPERWORK SHOULD BE COMPLETED PRIOR TO YOUR APPOINTMENT. IF, BY CHANCE, YOUR PAPERWORK IS NOT COMPLETED BEFORE YOU ARRIVE AT THE OFFICE AND IT IS NOT COMPLETED WITHIN 15 MINUTES OF YOUR SCHEDULED APPOINTMENT, YOUR APPOINTMENT WILL HAVE TO BE RESCHEDULED.

OUR OFFICE POLICY IS THAT PATIENTS WHO ARE 15 MINUTES LATE WILL BE RESCHEDULED.

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Please initial