



# San Joaquin Cardiology Medical Group, Inc.

**PLEASE PRINT CLEARLY**

DATE \_\_\_\_\_

DRIVER'S LIC. #
DATE OF BIRTH
HEIGHT                      WEIGHT
ALLERGIES
CHECK ONE <input type="checkbox"/> Male <input type="checkbox"/> Female
SOC. SEC. NO.
MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Other
HOME PHONE
BUSINESS PHONE
DATE OF BIRTH (MO/DAY/YR)
BUSINESS PHONE
REF. DR. PHONE
PHONE

PATIENT
HOME ADDRESS
CITY                                      STATE                                      ZIP
PATIENT EMPLOYED BY
NAME OF SPOUSE
EMPLOYED BY
PATIENT REFERRED BY
IN CASE OF EMERGENCY CONTACT (OTHER THAN SPOUSE)

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH \_\_\_\_\_ AND ASSIGN DIRECTLY TO SAN JOAQUIN CARDIOLOGY MEDICAL GROUP, INC. ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

<b>RESPONSIBLE PARTY INSURANCE INFORMATION</b>						
<table border="0"> <tr><td> _ _ _ _ _ _ _ _ _ </td><td> _ _ _ _ _ _ _ _ _ </td></tr> <tr><td>MEDICARE</td><td>MEDI-CAL</td></tr> </table>			_ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _	MEDICARE	MEDI-CAL
_ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _					
MEDICARE	MEDI-CAL					
PRIMARY INSURANCE COMPANY NAME	GROUP NO.	MEMBERSHIP NUMBER				
RESPONSIBLE PARTY NAME (IF OTHER THAN PATIENT)	RELATIONSHIP WITH PATIENT					
MAILING ADDRESS						
SECONDARY INSURANCE COMPANY NAME	GROUP NO.	MEMBERSHIP NUMBER				
MAILING ADDRESS						
RESPONSIBLE PARTY'S EMPLOYER						
MAILING ADDRESS						
HOW DID YOU LEARN OF US? <input type="checkbox"/> M.D. <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> ADVERTISEMENT <input type="checkbox"/> FRIEND						

San Joaquin Cardiology Medical Group  
Ramin Manshadi, M.D., F.A.C.C.  
2633 Pacific Ave  
Stockton Ca 95204  
944-5530

Patient name: \_\_\_\_\_

**DUE TO THE HIGH DEMAND IN THE TESTING THAT WE SCHEDULE FOR OUR PATIENTS, WE WOULD LIKE TO MAKE YOU AWARE OF THE "NO SHOW" FEES FOR THE TESTS THAT ARE SCHEDULED IN THE OFFICE.**

**NO SHOW FEE:**

\$25.00 ECHOCARDIOGRAM  
\$25.00 CAROTID ULTRASOUND  
\$25.00 ABI  
\$25.00 STRESS ECHO  
\$150.00 PERSANTINE CARDIOLITE STRESS TEST (NUCLEAR APPT.)  
\$25.00 HOLTER MONITOR NOT RETURNED THE FOLLOWING DAY  
\$2500.00 NON RETURNED HOLTER MONITOR

**I HAVE READ AND UNDERSTAND THAT SHOULD I NEED TO BE SCHEDULED FOR ANY OF THE ABOVE TESTS AND I FAIL TO SHOW UP FOR THE APPOINTMENT, I WILL BE CHARGED THE STATED NO SHOW FEE.**

Patient's signature \_\_\_\_\_

Date  
\_\_\_\_\_

SAN JOAQUIN CARDIOLOGY MEDICAL GROUP  
RAMIN MANSHADI, M.D.  
2633 PACIFIC AVE., STE. #1  
STOCKTON, CA 95204

## Acknowledgement of Receipt of Notice of Privacy Practices

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.

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: \_\_\_\_\_

# HEALTH HISTORY

(Confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

**SYMPTOMS** Check (✓) symptoms you currently have or have had in the past year.

<p><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p><b>EYE, EAR, NOSE, THROAT</b></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos	<p><b>MEN only</b></p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other
<p><b>MUSCLE/JOINT/BONE</b> Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p><b>WOMEN only</b></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other
<p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			<p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>

**CONDITIONS** Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
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<b>MEDICATIONS</b> List medications you are currently taking	<b>ALLERGIES</b> To medications or substances
Pharmacy Name _____	Phone _____

