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**>> Please complete this form and bring to your appointment**

### A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a service you receive is to be resolved in binding arbitration rather than a suite in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both health care providers and their patient have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some the rigors of trial and publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

Signature \_\_\_\_\_

Date \_\_\_\_\_

<b>Orange Office</b> 1140 W La Veta, Suite 640 & 670 Orange, Ca 92868 (714) 564-3300 Fax (714) 564-3318	<b>Bristol Office</b> 2621 S. Bristol St., Suite 204 Santa Ana, CA 92704 (714) 545-5170 Fax (714) 545-6724	<b>Irvine Office</b> 4050 Barranca Parkway, Suite, 200 Irvine, CA 92604 (949) 262-9600 Fax (949) 552-2759
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## Personal History

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Name

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Date

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Referring Doctor

Present Illness (in your own words)

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History (filled out by physician only)

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Please list all your medication, dosage and number of times taken daily.

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Please list past illnesses, Hospitalizations and injuries (dates included)

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Please list any medication and/or substances to which you are allergic, give type of reaction (eg: hives, wheezing, nausea, etc. that you experience)

Family History	If Living			If Deceased	
	Sex	Age	Health	Age of death	Cause
Father					
Mother					
Brothers & Sisters	M	F			
	M	F			
	M	F			
	M	F			
	M	F			
Husband/Wife					
Sons/Daughters	M	F			
	M	F			
	M	F			
	M	F			
	M	F			
	M	F			

**Do you know of any blood relative who has or had: (circle and give relationship)**

Stroke		Epilepsy		Stomach Ulcer	
Cancer		Suicide		Kidney Disease	
High B/P		Migraine		Goiter	
Tuberculosis		Asthma		Arthritis	
Diabetes		Hay Fever		Colitis	
Leukemia		bleeding		Nervous breakdown	
Insanity		congenital heart			
Rheumatic Heart		Heart Attack			

**Personal Habits: (circle)**

**Yes / No** 1. Do you regularly smoke? Cigarettes \_\_\_\_\_ Pipe \_\_\_\_\_ Cigars \_\_\_\_\_

**Yes / No** 2. Do you drink caffeinated coffee? How many cups per day? \_\_\_\_\_

Do you drink tea or soft drinks? How much per day? \_\_\_\_\_

**Yes / No** 3. Do you regularly drink alcohol? 1oz/day\_\_ 2oz/day\_\_ 4oz/day\_\_

Beer: 1 bottle/day\_\_\_\_\_ 2bottles/day\_\_\_\_\_ over 6\_\_\_\_\_