Zymek Cardiology, PLLC

Last Name:_____First Name:_____M.I. _____

Date of Birth:_____ Sex: **M** **F** Soc Sec #_____

Arizona address:_____City: _____ State:_____Zip: _____

Telephone: (Home)_____Cell:_____E-mail: _____

Secondary address:_____City:_____ State:_____Zip:_____

Marital status:_____Spouse/partners name: _____

Emergency Contact: _____Phone:_____relation: _____

Race:_____Language: _____

Ethnicity: (pick one) Hispanic/Latino Not Hispanic/Latino Refuse to report

Pharmacy:_____Cross streets:_____Phone: _____

Insurance Information:

Primary insurance:_____ID:_____Group #: _____

Policy holder:_____DOB:_____Relationship: _____

Soc Sec:_____Employer: _____

Secondary Insurance:

Primary insurance:_____ID:_____Group #: _____

Policy holder:_____DOB:_____Relationship: _____

Soc Sec:_____Employer: _____

I hereby give permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying my medical costs, but I am ultimately responsible for all medical services rendered, and if necessary, agree to pay all reasonable and customary fees and/or attorney fees that may occur if my account becomes delinquent. I authorize the release of any medical information necessary to process any claims to my insurance company. I furthermore authorize payment of medical benefits to go directly to my physician for services rendered.

Signature Parent/Guardian: _____ Date: _____

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Zymek may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare options (Treatment Payment Options). Please request a copy of Dr. Zymek Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Zymek reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by requesting a copy through the office or by forwarding a written request to the Privacy Officer at 6859 E. Rembrandt Ave., Ste 117, Mesa, AZ 85212.

With my consent, Dr. Zymek may call my home or other designated location and may leave messages on voicemail or in person in reference to any items that assist our office in carrying our Treatment Payment Options; such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results.

I wish to be contacted in the following manner (check all that applies):

- Home Phone Number_____
- O.K. to leave message with detailed info.
- O.K. to leave detailed msg. with person
- Leave msg. with call back number only
- Work Phone Number_____
- O.K. to leave msg. with detailed info.
- Written Communication
- O.K. to mail to my home address
- O.K. to mail to my work office
- O.K. to fax this number_____
- Persons we are able to leave a detailed msg with _____
- Leave message with call back # ONLY _____
- Persons we are NOT able to give PHI

  _____

  _____

I have the right to request that Dr. Zymek restrict how it uses or discloses my PHI to carry out Treatment Payment Options. However, the practice is not required to agree to my requested restriction, but if it does, it is bound to this agreement.

By signing this form, I am consenting to Dr. Zymek to use and disclose of my PHI to carry out Treatment Payment Options. I may revoke my consent in writing except in the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Zymek may decline to provide treatment to me.

_____ _____

Signature of Patient/Legal Guardian Date

Print Name of Patient _____

Patients Name: _____

Consent for Care and Treatment:

I, the undersigned do hereby agree and give my consent to Dr. Zymek Cardiologist/ to provide medical care and treatment considered necessary and proper in diagnosing or treating the above-named patient.

Patient/Responsible Party Signature: _____Date: _____

Privacy Practices

By signing below, I acknowledge that I have received a copy of Dr. Zymek Notice of Privacy Practices and have been provided an opportunity to review it. **Initial: _____**

Financial Policy/Notification of Patient Responsibility:

Dr. Zymek will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. If your insurance does not remit payment within 60 days, the balance will be due in full of you. In the event your insurance company establishes a usually and customary fee schedule, you will be responsible for the remaining balance. If any payment is made directly to you for services billed, you recognize an obligation to submit same payment to Dr. Zymek.

Your insurance company requires us to collect your co-payments, co-insurance, and/or any unmet deductible amounts from you at the time of services. If we do not collect these amounts, we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment and future contracting. In the event that a check is returned for Non-Sufficient Funds, a $35.00 service fee will be charged to you. **Initial:_____**

Cancellation Policy:

We do charge a $25 fee if you do not show up to a scheduled appointment or cancel the same day as your appointment. Please call us 24 hours in advance if you have to cancel your scheduled appointment.

We have verified your medical benefits with your insurance, based upon the information you provided. Please be advised that your insurance company has a disclaimer that this is verification of benefits only and does not guarantee payment. Benefits/payment is determined once claim is received.

Please note: any remaining balance will be billed to you once information/payment is received from your insurance company. By signing below, I acknowledge that I have read the above information, and that I am ultimately financially responsible for my treatment. I understand and agree that if I fail to make any payment that I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including but not limited to costs, collection agency and/or attorney's fees.

Signature of Patient/Guardian:_____Date:_____

NEW PATIENT MEDICAL HISTORY FORM **Date:** _____

Please complete the following questions for your physician's review.

NAME _____
First **Middle** **Last** **DOB**

Do you have a living will: Yes No Yes If yes, please provide us with a copy
How did you find out about us? Physician referral Relative or Friend Insurance Website
Others (please include) _____

Physician's Name: _____
Address: _____

MEDICAL HISTORY

Reason for today's visit:

_____
_____

Heart Health:

Have you had a 2-D Echocardiogram: Date:_____Physician:_____
Have you had a stress test Date:_____Physician:_____
Have you ever worn a Holter or event monitor Date:_____Physician:_____
Date of most recent bloodwork:_____Physician:_____
Ablation: Date_____Physician:_____
Heart valve repair or replacement: Date_____Physician:_____

Diabetes	YES [ ]NO [ ]	Hypertension	YES [ ]NO [ ]
Stroke	YES [ ]NO [ ]	Mini Stroke	YES [ ]NO [ ]
Congestive Heart Failure	YES [ ]NO [ ]	Heart Valve Problems	YES [ ]NO [ ]
Rheumatic Heart Disease	YES [ ]NO [ ]	High Cholesterol	YES [ ]NO [ ]
Irregular Heart Rhythm/Arrhythmia	YES [ ]NO [ ]	Aneurysm	YES [ ]NO [ ]
Pacemaker	YES [ ]NO [ ]	Pneumonia	YES [ ]NO [ ]
COPD	YES [ ]NO [ ]	Sleep Apnea	YES [ ]NO [ ]
Home Oxygen Use	YES [ ]NO [ ]	Asthma	YES [ ]NO [ ]
Arthritis	YES [ ]NO [ ]	Osteoporosis	YES [ ]NO [ ]
Cancer (specify) _____	YES [ ]NO [ ]	Thyroid Disease	YES [ ]NO [ ]
Anemia	YES [ ]NO [ ]	Bleeding Disorders	YES [ ]NO [ ]
Blood Clots	YES [ ]NO [ ]	Liver Disease or Hepatitis	YES [ ]NO [ ]
Stomach Ulcers	YES [ ]NO [ ]	Polyps or Acid Reflux	YES [ ]NO [ ]
Diverticulitis or Diverticulosis	YES [ ]NO [ ]	Hernias	YES [ ]NO [ ]
Infections (specify) _____	YES [ ]NO [ ]	Kidney Disease	YES [ ]NO [ ]
Prostate Disease	YES [ ]NO [ ]	Dementia	YES [ ]NO [ ]
Depression (specify) _____	YES [ ]NO [ ]	Other _____	YES [ ]NO [ ]

Past Medical History: Please check all boxes that apply

CHILDHOOD DISEASES

Measles	YES	NO	Rubella (German Measles)	YES	NO
Mumps	YES	NO	Chickenpox (Varicella)	YES	NO

Others:_____

PAST SURGICAL HISTORY

Heart Surgery (bypass)	YES	NO	Valve Surgery	YES	NO
Cardiac Birth Defect Surgery	YES	NO	Angioplasty/Stents	YES	NO
Pacemaker (defibrillators)	YES	NO	Carotid Surgery	YES	NO
Aneurysm Repair Surgery	YES	NO	Tumor Removal	YES	NO

Others:_____

FAMILY HISTORY

Hypertension	YES	NO	Obesity	YES	NO
Sudden Death	YES	NO	Heart Attack	YES	NO
Stroke	YES	NO	High Cholesterol	YES	NO
Diabetes	YES	NO			
Bleeding or Blood Clotting Abnormalities	YES	NO			

Others:_____

RISK FACTORS

Diabetes	YES	NO	Peripheral Arterial Disease	YES	NO
High Cholesterol	YES	NO	Hypertension	YES	NO
Alcoholism	YES	NO			
Smoking (___ packs per day) ____ Years Smoked	YES	NO			

SOCIAL HISTORY

Occupation: _____ Marital Status: _____

Tobacco Use	YES	NO	Exercise Habits	YES	NO
Caffeine Use	YES	NO	Diabetes	YES	NO
Recreational Drug Use	YES	NO	Sexually Active	YES	NO
Alcohol Use	YES	NO	Heart Attack	YES	NO
Recent Travel Outside of Country	YES	NO			

MEDICATIONS	**HOW LONG HAVE YOU BEEN TAKING?**
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES (LIST ALL MEDICATIONS THAT YOU ARE ALLERGIC TO & WHAT YOUR REACTION IS)

_____
_____

OTHER ALLERGIES (i.e. tape, environmental, substances, dye, etc.)

_____
_____

RECENT IMMUNIZATIONS

Pneumovax Hepatitis A Hepatitis B Shingles HPV Influenza

Recent Hospitalizations within the past 2 years & reason for hospitalization

_____

_____

REVIEW OF SYMPTOMS

GENERAL

Fever
Night Sweats
Chills
Weakness
Fatigue
Weight gain of more than 10lbs in the past one year
Weight loss of more than 10lbs in the past one year
Sensitivity to heat of cold
Loss in height of more than 2 inches

RESPIRATORY

Cough
Chest Pain
Shortness of Breath with or without exertion
Wheezing
Coughing of Blood

CARDIOVASCULAR

Chest Pain At Rest With Exertion
Leg or Hip Pain On Walking On Standing
Palpitations
Passing Out Spells
Feeling Faint
Dizziness
Leg or Extremity Sweating
SOB at Rest
SOB with Exertion

GASTROINTESTINAL

Nausea
Vomiting
Vomiting Blood
Heartburn
Diarrhea
Blood in Stool
Loss of Appetite
Abdominal Pain
Indigestion
Hemorrhoids
Pain While Swallowing

NEUROLOGIC

Blurred Vision
Double Vision
Blindness
Slurred Speech
Loss of Memory
Seizures
Headache
Weakness of Body Parts
Numbness/Tingling
Difficulty Swallowing
Difficulty in Equilibrium
Instability while Walking

GENITOURINARY

Frequent Urination
Blood in Urine
Dark Urine
Pain/Burning w/Urination
Vaginal Discharge or Abd. Bleeding
Freq. Getting up at Night to Urinate
Inability to achieve/maintain erection
Lack of Libido
Dribbling of Urine
Irregular Menses
Painful Periods

PSYCHIATRIC

Depression
Anxiety
Excess Stress
Irritability
Memory Loss

SKIN

Abnormal Skin Growth or Discoloration
Rash