Zymek Cardiology, PLLC

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Gender: **M** **F** Soc. Sec#: _____

Primary Address: _____ City: _____ State: _____ Zip: _____

Second Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email Address: _____ Web Enable: (circle one) **YES** **NO**

Marital Status: _____ Spouse/Partners Name: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Race: _____ Language: _____ Ethnicity: **(circle one)** Hispanic/Latino Not Hispanic/Latino Refuse to Report

Preferred Pharmacy: _____ Cross Street: _____Phone: _____

Primary Insurance:

Name of Insurance: _____ ID: _____ Group# _____

Policy holder: _____ DOB: _____ Relationship: _____

Soc Sec: _____ Employer: _____

Secondary Insurance:

Name of Insurance: _____ ID: _____ Group# _____

Policy holder: _____ DOB: _____ Relationship: _____

Soc Sec: _____ Employer: _____

Name of Primary Care Provider: _____ **Phone:** _____

I hereby give permission to treat myself 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.

Patient (or Parent/Guardian) Signature: _____ Date: _____

Patient Consent for use and Disclosure of Protected Health Information

With my consent, *Zymek Cardiology*, PLLC 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 *Zymek Cardiology*, PLLC 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. *Zymek Cardiology*, PLLC 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 6641 E Baywood Ave STE A4, Mesa, AZ 85206.

With my consent, *Zymek Cardiology*, PLLC 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 out 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 apply):

- Primary Phone: _____
- OK to leave detailed message on voicemail
- OK to leave detailed msg with person other than patient
- Person(s) who have permission to speak or who may receive information on your behalf:

  _____

  _____

  _____

  _____
- Secondary Phone. _____
- OK to send written communication to Primary address on file
- There is no person whom I give permission to speak or communicate regarding my care.

I have the right to request *Zymek Cardiology*, PLLC 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 restrictions, but if it does, it is bound to this agreement.
By signing this form, I am consenting to *Zymek Cardiology*, PLLC 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, *Zymek Cardiology*, PLLC *may* decline to provide treatment to me.

Signature of Patient (or Parent/Guardian): _____ Date: _____

Printed Name: _____

Patients Name: _____ **DOB:** _____

Consent for Care and Treatment:

I, the undersigned to hereby agree and give my consent to *Zymek Cardiology*, PLLC 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 *Zymek Cardiology*, PLLC Notice of Privacy Practices and have been provided an opportunity to review it. **Initial:** _____

Financial Policy/Notification of Patient Responsibility:

Zymek Cardiology, PLLC 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. In the event your insurance company establishes a usual 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 payment to *Zymek Cardiology*, PLLC.

Your insurance company requires us to collect co-payments, co-insurance and/or any unmet deductible amounts from you at the time services are rendered. 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 a Non-Sufficient Fund, a $35.00 service fee will be charged to you. **Initial:** _____

Cancellation Policy for No-Showed Appointments, Testing or Procedures:

When patients miss any appointments or cancel without providing prior notice it prevents another patient from being scheduled and receiving care during that time slot. Our policy at *Zymek Cardiology*, PLLC is to charge a $25.00 fee for any missed appointments with Dr. Zymek or Kylee Huebsch, FNP and $50.00 for any testing (excluding Nuclear Stress Test) IF you have not provided at least 24 hours of notification. These fees will be billed to the patient. This bill is not covered by insurance and must be paid PRIOR to your next appointment. Thank you for your cooperation and understanding as we strive to best serve the needs of our patients.

By signing below, you acknowledge that you have received this notice and understand all financial policies regarding policy for care and treatment at *Zymek Cardiology*, PLLC.

Print Name: _____

Signature: _____ **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 If yes, please provide us with a copy

How did you find out about us? Physician Referral Friend or Relative Insurance Website

Other (please include) _____

MEDICAL HISTORY

Reason for today's visit: _____

Heart Health:

Have you had an Echocardiogram (Ultrasound of your heart) **Y/N** Date: _____ Physician_____

Have you had a cardiac stress test? **Y/N** Date: _____ Physician: _____

Have you ever worn a Holter or Event Monitor? **Y/N** Date: _____ Physician: _____

Date of most recent lab work? _____ Physician: _____

Have you ever had a cardiac ablation? **Y/N** Date: _____ Physician: _____

Have you ever had a cardiac valve replacement? **Y/N** Date: _____ Physician: _____

Please circle **Yes** or **No** if any of the following apply to you and your Medical History:

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

Past Medical History

Childhood Diseases: Please circle Yes if you had or were vaccinated for the following childhood illnesses

Measles	Yes	No	List vaccines you have received: (i.e. Covid, Shingles, Flu)
Mumps	Yes	No	_____
Rubella (German measles)	Yes	No	_____
Chickenpox (Varicella)	Yes	No	_____

Past Cardiac Surgical History: Have you had any of the following Cardiac Surgeries? (circle Yes or No)

Cardiac Bypass	Yes	No	Date: _____	Valve Surgery	Yes	No	Date: _____
Angioplasty/Stents	Yes	No	Date: _____	Pacemaker/Defib	Yes	No	Date: _____
Carotid Surgery	Yes	No	Date: _____	Aneurysm Repair	Yes	No	Date: _____

Any other cardiac surgeries: _____

Family History: Only circle if your biological family member had any of the issues listed below

M=Mother F=Father S=Sibling

Hypertension	M	F	S	Sudden Death	M	F	S
Diabetes	M	F	S	Obesity	M	F	S
Heart Attack	M	F	S	High Cholesterol	M	F	S
Stroke	M	F	S	Bleeding/Clot Disorder	M	F	S

Social History: Answer the by circling Yes or No and check mark which best describes the answer

Tobacco usage	Yes	No	**Never**___	**Current**___ (amount___)	**Quit**___ (when___?)
Caffeine usage	Yes	No	amount per day ___		
Recreational Drugs	Yes	No	**Never**___	**Current**___ (amount___)	**Quit**___ (when___?)
Alcohol use	Yes	No	**Never**___	**Current**___ (amount___)	**Quit**___ (when___?)
Exercise Habits	Yes	No	**If yes, how often and duration?** _____		

Occupation: _____ Any Recent Travel Outside of the Country? Yes No

Medication List: Include the name of the medication, dosage, how often (List attached separately Y/N)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies to Medications: Please list only the medications you are Allergic to:

_____

_____

Other Allergies (i.e. medical tape, dye environmental substances, etc.)

_____

_____

Recent Hospitalizations within the past 2 years/reason for hospitalization:

Review of System: Please circle only the symptoms you are *currently or have recently* experienced:

GENERAL:

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

RESPIRATORY:

Cough	Shortness of Breath	Wheezing	Coughing up Blood

CARDIOVASCULAR:

Chest Pain with activity	Chest Pain at Rest	Passing out spells
Shortness of Breath with activity	Shortness of Breath at rest	Dizziness
Swelling in arms and/or legs	Feeling Faint	Palpitations

GASTROINTESTINAL:

Nausea	Vomiting	Abdominal Pain	Diarrhea
Blood in stool	Indigestion	Vomiting blood	Black stool
Hemorrhoids	Heartburn	Loss of appetite	Pain while swallowing

NEUROLOGICAL:

Blurred vision	Doubled Vision	Blindness	Headache
Slurred Speech	Seizures	Standing/Walking Imbalance	Weakness of body parts
Numbness/Tingling in extremities		Difficulty in Equilibrium	Memory Loss

PSYCHIATRIC:

Depression	Anxiety	Excess Stress	Irritability