San Tan
CARDIOVASCULAR
CENTER

Welcome to our Practice!

Please completely fill out the enclosed patient information forms and bring the **completed** forms to our office on your appointment date. Completing these forms in their entirety **prior** to your appointment will help your appointment to run more smoothly.

Also, please remember to bring a **PHOTO ID**, your **INSURANCE CARD(S), COPAY,** and a **COMPLETE LIST OF YOUR MEDICATIONS** (including the medication name(s), dosages and how often you take them.

Should you have any questions, please feel free to call our office. Thank you and we look forward to caring for you!

Sincerely,

San Tan Cardiovascular Center

6859 E. Rembrandt Ave, Suite 117, Mesa AZ 85212 - 6740 S. Kings Ranch Rd, Suite 103, Gold Canyon AZ 85118 - 3980 E Riggs Rd, Bldg. 4 Suite 2, Chandler, AZ 85249

Phone: 480-632-1577 www.santancv.com

San Tan
CARDIOVASCULAR
CENTER

PATIENT REGISTRATION

(Complete ALL Sections)

Patient Information

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

Birthdate: _____ Sex: M F Social Security #: _____

Arizona Address: _____ City: _____ Zip: _____

Secondary Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Primary Care Physician: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relation: _____

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

Pharmacy: _____ Cross Streets: _____ Phone: _____

Primary Insurance Information

Insurance: _____ ID: _____ Group #: _____

Policy Holder: _____ DOB: _____ Relation: _____

Social Security #: _____ Employer: _____

Secondary Insurance Information

Insurance: _____ ID: _____ Group #: _____

Policy Holder: _____ DOB: _____ Relation: _____

Social Security #: _____ 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: _____ Date: _____

San Tan CARDIOVASCULAR CENTER

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PATIENT CONSENT for USE and DISCLOSURE of PROTECTED HEALTH INFORMATION

With my consent, San Tan Cardiovascular Center, LLC 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 San Tan Cardiovascular Center's 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. San Tan Cardiovascular Center 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. Suite 117, Mesa, AZ 85212.

With my consent, San Tan Cardiovascular Center 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 pertained to my clinical care, including laboratory results.

☐ **I wish to be contacted by all of the following methods (cross through ones that don't apply):**

Cell Phone Number: _____

- OK to leave text message with detailed information
- Leave message with call back number only

Home Phone Number: _____

- OK to leave message with detailed information
- OK to leave detailed message with person
- Leave message with call back number only

Written Communication

- OK to mail to my home address
- OK to mail to my work address
- OK to fax to this number

_____

Web Enabled for Patient Portal

- OK to send messages through Portal

Persons we **CAN** leave a detailed message with:	Persons we **CANNOT** give information to:

I have the right to request that San Tan Cardiovascular Center 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 San Tan Cardiovascular Center 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, San Tan Cardiovascular Center, LLC may decline to provide treatment to me.

Signature of Patient / Legal Guardian: _____

Printed Name: _____ Date: _____

San Tan CARDIOVASCULAR CENTER

Patient Name: _____

Consent for Care and Treatment:

I, the undersigned do hereby agree and give my consent *to San Tan Cardiovascular Center* to provide medical care and treatment considered necessary and proper in diagnosing or treating the above named patient.

Patient / Responsible Party Signature:

Sign: _____ Date: _____

Privacy Practices

By signing below, I acknowledge that I have received a copy of *San Tan Cardiovascular Center's* Notice of Privacy Practices and have been provided an opportunity to review it. **Initial: _____**

Financial Policy / Notification of Patient Responsibility

San Tan Cardiovascular Center 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 from 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 San Tan Cardiovascular Center.

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 service fee will be charged to you. **Initial: _____**

Cancellation Policy

We do charge a $50 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.

If you are scheduled for a NUCLEAR STRESS TEST, and cancel the day of the appointment, you will be charged a $100 fee. The radioisotope we order is SPECIFICALLY for you. It cannot be used on someone else and has to be used within a specific time frame. Any radioisotope not used is then wasted and we are charged for that as well. Please call us 24 hours BEFORE your appointment to reschedule.

Insurance Verification

We will / have verified your medical benefits with your insurance, based upon the information you provided. Please be aware that your insurance has a disclaimer that this is VERIFICATION OF BENEFITS *only* and does not guarantee payment. Benefits / payment is determined once the 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.

Patient / Guardian: _____ Date: _____

SanTan CARDIOVASCULAR CENTER

NEW PATIENT MEDICAL HISTORY FORM

LAST NAME: _____ FIRST NAME: _____ MI _____

DOB: _____ Date: _____

Primary Physician Name: _____

Address: _____

Reason for today's visit:

- ☐ Establish care with practice
- ☐ Specific complaint or concern
- ☐ Establish with cardiologist
- ☐ Second Opinion
- ☐ Other: Please specify:

_____

How did you find out about us?

- ☐ Physician Referral
- ☐ Relative or Friend
- ☐ Insurance
- ☐ Website
- ☐ Hospital
- ☐ Internet

Other please specify:

_____

MEDICATIONS

Allergies- Please List any medication allergies or intolerances and reactions:

_____

_____

Please List all your current medications (Including supplements, vitamins and over the counter):

	MEDICATION NAME	DOSAGE
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Past Medical History (Please complete the following questions for your physician's review)

	Y	N		Y	N		Y	N
Diabetes			**Stomach Ulcer**			**Aneurysm**		
High Cholesterol			**Diverticulitis**			**Sleep Apnea**		
Congestive Heart Failure (CHF)			**Hernia**			**Pneumonia**		
Hypertension			**Polyps**			**Depression**		
Heart Arrhythmia			**Acid Reflux**			**Osteoporosis**		
COPD			**Bleeding Disorder**			**Prostate Disease**		
Asthma			**Anemia**			**Heart Valve Problems**		
Home Oxygen Use			**Blood Clots**			**Dementia**		
Arthritis			**Mini Stroke (TIA)**			**Hepatitis**		
Thyroid Disease			**Stroke**			**Cancer**		
Kidney Disease			**Alcohol Abuse**			**Covid-19**		
Liver Disease								

Have you had a previous:

Heart Attack (MI)? ☐ YES ☐ NO Date: _____
Coronary Heart Stents? ☐ YES ☐ NO Date: _____
Heart Bypass Surgery? ☐ YES ☐ NO Date: _____
Peripheral (leg) stents? ☐ YES ☐ NO Date: _____
Birth Defect heart surgery? ☐ YES ☐ NO Date: _____
Carotid Surgery? ☐ YES ☐ NO Date: _____

Childhood Diseases:

☐ **Measles**
☐ **Mumps**
☐ **Rubella**
☐ **Chickenpox**

Other:_____
_____

Have you had Heart Valve surgery? ☐ YES ☐ NO

☐ Aortic Valve ☐ Bioprosthetic (tissue) ☐ Repair ☐ TAVAR ☐ Mechanical
☐ Tricuspid Valve ☐ Bioprosthetic (tissue) ☐ Repair ☐ Mitral Clip ☐ Mechanical
☐ Mitral Valve ☐ Bioprosthetic (tissue) ☐ Repair
☐ Pulmonary Valve ☐ Bioprosthetic (tissue) ☐ Repair

Do you have an Implantable Cardiac Device? ☐ YES ☐ NO

☐ Implantable Defibrillator (ICD) ☐ Pacemaker ☐ Loop Recorder ☐ Watchman ☐ Biotronik
☐ CardioMEMS ☐ LVAD ☐ Abbott (St Jude) ☐ Medtronic ☐ Boston Scientific

Have you recently been admitted to the hospital for cardiac symptoms? ☐ YES ☐ NO

If yes, when and where? _____

In the last year, have you had any cardiac testing? ☐ YES ☐ NO

If yes, what, when and where? _____
_____

When was your last eye exam? _____ **Do you have:** ☐ Eyeglasses ☐ Contacts

Surgical History

DESCRIPTION	YEAR

Hospitalizations

DESCRIPTION	YEAR

Do you have a Living Will? YES ☐ NO ☐ If *yes*, please provide us with a copy.

Excessive Work or Home Exposure

☐ Fumes ☐ Chemicals ☐ Noise ☐ Dust ☐ Solvents ☐ Pollutants ☐ Radiation

Family History	Mother	Father	Brother	Sister
☐ Hypertension	☐	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐
☐ High Cholesterol	☐	☐	☐	☐
☐ Heart Attack	☐	☐	☐	☐
☐ Heart Arrhythmia	☐	☐	☐	☐
☐ Stroke	☐	☐	☐	☐
☐ Obesity	☐	☐	☐	☐
☐ Bleeding Disorder	☐	☐	☐	☐
☐ Other: _____				

Family History - Please check all that apply Are you adopted? ☐ Yes

Father ☐ Living ☐ Deceased ☐ Cause of Death / age: _____

☐ Cardiac Illnesses: _____

Mother ☐ Living ☐ Deceased ☐ Cause of Death / age: _____

☐ Cardiac Illnesses: _____

Social History

Marital Status ☐Married ☐ Single ☐ Widowed ☐ Divorced

Employment statues ☐ Full Time ☐ Part time ☐ Retired ☐ Student

List your occupation _____

YES	NO		
		Smoker	Packs / Day
		Former Smoker	When did you quit?
		Vaping	Quantity Daily
		Alcohol	Quantity Daily
		Recreational Drugs	Quantity Daily & Type
		Exercise	Days / Week
		Sexually Active	
		Recent travel outside of the country?	Where to?

Recent Immunizations ☐ Pneumovax ☐ Hepatitis A ☐ Hepatitis B ☐ Shingles ☐ HPV ☐ Influenza

Year: _____

☐ **Covid-19 Vaccine** If *yes*, please provide us with a copy to document date and Lot #. Date: _____

REVIEW OF SYMPTOMS

Please check all that apply

Constitutional:

☐ Weight Loss ☐ Weight Gain ☐ Fatigue

Cardiovascular:

☐ Angina, Chest Pain ☐ Abnormal blood pressure ☐ Abnormal heart rate ☐ Abnormal EKG ☐ Hypertension ☐ Palpitations ☐ Heart Attack ☐ Edema, Swelling in legs or feet ☐ Arrhythmia ☐ Heart Murmur ☐ Edema, Swelling in abdomen ☐ Passing out or Black-out Spells ☐ Congenital Heart defects ☐ Claudication ☐ Leg pain ☐ R ☐ L ☐ Varicose (☐ R ☐ L) ☐ Restless legs (☐ R ☐ L) ☐ Leg discoloration (☐ R ☐ L)

Respiratory:

☐ Cough ☐ Coughing up blood ☐ Shortness of Breath ☐ COPD ☐ Asthma ☐ Pneumonia

Ear, Nose and Throat (ENT):

☐ Difficulty hearing ☐ Ringing in ears ☐ Vertigo ☐ Bleeding Gums ☐ Sore Throat ☐ Allergies

Gastrointestinal:

☐ Heartburn ☐ Nausea/Vomiting ☐ Blood in Stool ☐ Change in bowel movement ☐ Constipation ☐ Diarrhea ☐ Abdominal Pain ☐ Hemorrhoids ☐ Ulcers

Genitourinary:

☐ Pain while Urinating ☐ Burning while Urinating ☐ Difficult Urinating

Hematologic:

☐ Bruising Easily ☐ Anemia ☐ Enlarged Glands

Musculoskeletal:

☐ Arthritis ☐ Decreased Motion ☐ Gout ☐ Back Pain ☐ Muscle Pain ☐ Neck Pain ☐ Joint Pain ☐ Joint stiffness

Skin:

☐ Rash or Sores ☐ Itching/Burning Skin ☐ Psoriasis

Neurological:

☐ Dizziness ☐ Seizures ☐ Weakness ☐ Numbness ☐ Tremor ☐ Headache ☐ Spasticity (Spasm) ☐ Memory Loss ☐ Stroke ☐ Speech impairment ☐ Difficulty with walking ☐ Difficulty with balance

Psychiatric:

☐ Anxiety ☐ Depression ☐ Insomnia

Patient or authorized person's signature: _____

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theatre or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

PERIPHERAL ARTERY DISEASE (PAD)

PAD INITIAL SYMPTOM CHECKLIST ***Things to discuss with your doctor***

What is PAD?

PAD stands for **Peripheral Artery Disease** which is a condition where deposits, called calcium or plaque, build up over time on the inside walls of the arteries in your legs. This build up causes the arteries to narrow, reducing blood flow to the legs and feet.

Some Facts about PAD

- Between 8 million and 12 million Americans have PAD
- One in three people over the age of 50 with diabetes is likely to have PAD
- >50% of the 160,000 individuals who have a leg or foot amputated each year never had a vascular diagnostic evaluation to determine if blood flow could be restored.

Some risk factors that increase the chance you may develop PAD:

	Yes	No
Are you 50 years or older?		
Do you smoke or did you smoke?		
Have you been diagnosed with any of the following?		
Diabetes?		
Chronic Kidney Disease?		
High Blood Pressure?		
High Cholesterol?		
Have you experienced tiredness, heaviness, or cramping in the leg muscles?		
Do your toes or feet look pale, discolored or bluish?		
Pain in the legs and/or feet that disturb sleep?		
Sores or wound on toes, feet, or legs that heal slowly or not at all?		
One leg or foot feels colder than the other?		
Poor nail growth and decreased hair growth over time on legs and toes?		

SanTan CARDIOVASCULAR CENTER

VENOUS SELF-ASSESSMENT

Please take this self-assessment to see if you need additional screening for potential varicose veins and/or chronic venous insufficiency.

History

Have you ever had varicose veins?	Yes	No

Signs and Symptoms

Do you experience any of the following signs and symptoms in your legs or ankles?

Do you experience leg pain, aching or cramping?	Yes	No
Do you experience leg or ankle swelling, especially at the end of the day?	Yes	No
Do you feel “heaviness” in your legs?	Yes	No
Do you experience restless legs?	Yes	No
Do you have skin discoloration or texture changes?	Yes	No
Do you experience “itchiness” on your legs?	Yes	No

Risk Factors

Has anyone in your blood-related family ever had varicose veins or been diagnosed with venous reflux disease or chronic venous insufficiency?	Yes	No
Have you had any treatments or procedures for vein problems?	Yes	No
Do you stand for long periods of time, such as at work?	Yes	No

Self-Assessment Results

If you answered yes to one or more of the above questions please contact us for a consultation to see if you might have venous reflux disease.