Cardiology Associates of Michigan, P.C.

Shelby Medical Mall-50505 Schoenherr rd. Suite 320 Shelby MI 48315 Ph☹586)580-3062 Roseville Office: 25910 Kelly Rd Suite B Roseville, MI 48066 Ph: (586)772-3366. East China Office: 4014 River Rd Bldg. 2B East China, MI 48054 Ph: (810)326-0643

As a part of your Patient-Centered Medical Home Neighborhood, we welcome you to our Specialty Practice!

We are partnering with your Primary Care Physician (PCP) who is your *Patient Centered Medical Home.* We are sharing their commitment to effectively and efficiently work together to manage your care. As your Specialist, we will be sharing information about your condition and provide recommendations, guidance and periodic follow-up.

A Patient-Centered Medical Home - neighborhood (PCMH-n) is a system of care in which a team of health professionals work together to provide your entire healthcare needs.

You, the patient, are the most important part of the PCMH-n. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need.

We trust you as our patient to:

- Keep your appointments as scheduled or call and let us know when you are unable to keep your appointment.
- Make healthy decisions about your daily habits and lifestyle
- Seek the advice of your PCP before you see other physicians.
- Follow the care plan that is agreed upon-or let us know why you cannot follow the plan so we can try to help you.
- Provide a current medication list at every appointment
- Tell us what medications you are taking.
- See your PCP for all preventive services

As your Specialist I will:

- Communicate with your Primary Care Physician (PCP) and provide timely written reports.
- Notify your PCP of no-shows, cancellations and other actions that may place your care in jeopardy.
- Notify your PCP if you are being referred to another specialist
- Remind you of tests due and inform you of your test results
- End every visit with clear instructions about expectations, treatment goals, and how I will coordinate with your PCP

Coordination of care and communication back to your PCP is my priority. Should you have other physicians managing your care please inform them that I am the specialist managing your cardiac condition and that I require communication regarding any treatment that may affect my treatment plan.

Mark A. Zainea, M.D.
Nancy A. Mesiha, M.D.
Zain Azzo, M.D.

Mouhammed A. Joumaa, M.D.
Majid Mesgarzadeh, M.D.
Sherezade Khambatta, D.O.

Michael D. Castillo, M.D.
Sheel Y.Tolia, D.O.
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PRACTICE HOURS

Shelby	Roseville	East China	Romeo Plank
Monday - Thursday	Monday – Friday	Monday - Friday	Tuesday, Thursday, Friday
8:30am - 4:30pm	8:30am- 4:30pm	8:30am - 4:30pm	*Various*

- Should you have an AFTERHOURS issue, please contact me for your cardiac condition such as elevated blood pressure, irregular heart rate, and chest pain. I will direct you with next steps
- If it is non-emergent, please contact the office during open hours and the staff will instruct you further
- Should you have an issue not pertaining to my care please contact your Primary Care Physician
- Should you need a refill on a medication that I prescribed for you please contact my office during business hours

Ask any of our staff about Community Services or contact the following:

NEED HELP? 2-1-1 is now available. Dial 211 from any phone and you will be connected with a referral hotline that can connect you with non-profit agencies in your area that can help with Human, Health and social needs (i.e., utilities, housing, health insurance, food, diapers, etc.)

A listing of the area resources can also be found on this website:
http://www.referweb.riet/ uwjc

Ask about our Patient Web Portal.
We have a Patient Portal that supports two-way, secure and compliant communication

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PATIENT INFORMATION:

Patient Name: _____
Last First Middle Nickname

Social Security: _____ Date of Birth: _____ Sex: _____

Billing Address: _____
Street Street 2 City State Zip

Secondary: _____
Street Street 2 City State Zip

Race: _____ Primary Language: _____ Circle: Hispanic or Latino? ◯ Yes ◯ No

Marital Status: _____ Primary Care Physician: _____

Home Phone: _____ Day Phone: _____

Cell Phone: _____ Secondary Address Phone: _____

Emergency Contact: _____ Emergency Contact Phone: _____
Other than Spouse

Email Address for Patient Portal: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Circle One: ◯ Self ◯ Spouse ◯ Dependent ◯ Other

Card Holder Name: _____ Employer: _____
If other than patient

Social Security: _____ Date of Birth: _____ Circle: ◯ Active ◯ Retired
If other than patient If other than patient

Secondary Insurance: _____ Circle One: ◯ Self ◯ Spouse ◯ Dependent ◯ Other

Card Holder Name: _____ Employer: _____
If other than patient

Social Security: _____ Date of Birth: _____ Circle: ◯ Active ◯ Retired
If other than patient If other than patient

Tertiary Insurance: _____ Circle One: ◯ Self ◯ Spouse ◯ Dependent ◯ Other

Card Holder Name: _____ Employer: _____
If other than patient

Social Security: _____ Date of Birth: _____ Circle: ◯ Active ◯ Retired
If other than patient If other than patient

Authorization To Pay Benefits to Physician:

I hereby authorize payment directly to Cardiology Associates of Michigan, P.C. otherwise payable to me for services rendered. I understand the provider's charge may exceed the private insurance carrier payment. If the physician does not participate with my insurance I will be responsible for the difference. I also understand that the fees for any services performed that are not contact benefits will be my financial responsibility.

Authorization To Release Information:

I hereby authorize Cardiology Associates of Michigan, P.C. to release any information necessary to process this claim.

_____
Signature (Patient or Guardian) Date

Due to the specialized nature of this practice, the time requirements for each patient will vary. The treatment of cardiac patients may cause unavoidable delays. Waiting time is inevitable. We recognize your time is valuable, and every effort is being made to minimize these delays. Your understanding and cooperation are greatly appreciated.

Thank you

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HIPAA Notice and Acknowledgement

I,_____, acknowledge that I have received the attached Notice of Privacy Practices.

_____ _____
Patient or Guardian Signature Date

The following authorizations will remain in effect until revoked in writing by the patient or the patient's authorized personal representative.

In compliance with the Privacy Practices of Cardiology Associates of Michigan, P.C., I authorize Cardiology Associates of Michigan, P.C. and its agents to disclose and/or discuss my Private Health Information (PHI) with the following individuals:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I authorize Cardiology Associates of Michigan, P.C. and its agents to leave messages regarding my PHI on a telephone answering machine or voice mail service.
Please check appropriate box:

- ☐ Yes
- ☐ Yes, with restrictions:_____
- ☐ No

_____ _____
Patient or Guardian Signature Date

Appointment date:_____with Dr. _____

Cardiology Associates of Michigan, P.C.

Patient Name: _____ DOB: _____ Sex: _____

Primary Care Doctor:_____Phone Number: _____

Pharmacy:_____Phone Number:_____Crossroads: _____

Reason for Visit: Please check all that apply

❑ Abnormal EKG	❑ Edema/Swelling	❑ Peripheral Vascular Disease
❑ Abnormal Labs	❑ Fatigue	❑ Post MI
❑ Arrhythmia	❑ Heart Murmur	❑ Post Operative Surgery
❑ Cardiomyopathy	❑ Hospital Follow up	❑ Second Opinion
❑ Cath/Angioplasty Follow up	❑ Hypertension (High BP)	❑ Shortness of Breath/Dyspnea
❑ Chest Pain/Discomfort	❑ Hypotension (Low BP)	❑ Surgical Clearance
❑ Congestive Heart Failure	❑ Other:_____	❑ Testing Follow up
❑ Coronary Artery Disease	❑ Pacemaker/ICD Follow up	❑ Valvular Disease
❑ Dizziness/Fainting	❑ Palpitations	

Allergies and Reactions (List any medications or foods including IV dye, shellfish or seafood)**:**

Allergy	Reaction

Cardiac Risk Factors:

Tobacco Use: ❑ Current, daily ❑ Current, some days ❑ Former ❑ Never

Type? _____
Units/Packs per day: _____ Years used: _____
Ever try to quit? ❑ Yes ❑ No Year quit? _____
Passive smoke exposure? ❑ Yes ❑ No

Alcohol Use: ❑ Current ❑ Former ❑ Never Year Quit?_____

❑ Daily ❑ Frequently ❑ Occasionally ❑ Socially ❑ Rarely ❑ Never

Drug Use: ❑ Current ❑ Former ❑ Never Type? _____ Year Quit? _____

❑ Daily ❑ Frequently ❑ Occasionally ❑ Socially ❑ Rarely ❑ Never

❑ Inhaled ❑ IV ❑ Oral ❑ Smoked ❑ Snorted

Diabetes: ❑ Yes ❑ No If so, what type? ❑ Type 1 (Juvenile) ❑ Type 2 (Adult Onset)

Family Hx: Has any member in you family been diagnosed with heart disease before the age of 65? ❑ Yes ❑ No

Have you ever been diagnosed with any of the following?

Peripheral Vascular Disease	❑ Yes	❑ No	❑ Unknown
Hypertension	❑ Yes	❑ No	❑ Unknown
Dislipidemia	❑ Yes	❑ No	❑ Unknown

Forwarding Documents: Please list the names of any physician's you would like to have your records sent to

Physician:_____City/State:_____Phone #: _____
Physician:_____City/State:_____Phone #: _____
Physician:_____City/State:_____Phone #: _____

FOR INTERNAL USE ONLY

Referring Physicians: _____

Weight: _____ Height: _____ BMI: _____ BP:_____/_____ Arm: L / R HR: _____ O2: _____

Patient Name: _____

Past Medical History: Please check any of the following conditions that you currently HAVE or HAVE had

HEENT:
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Headache/Migraine
- ❑ Macular Degeneration

Endocrine:
- ❑ Goiter
- ❑ Hyperthyroidism
- ❑ Hypoparathyroidism
- ❑ Hypothyroidism

Gastrointestinal:
- ❑ Barrett's Esophagus
- ❑ Crohn's Disease
- ❑ Diverticulitis
- ❑ Diverticulosis
- ❑ GERD/Reflux
- ❑ Hepatitis
- ❑ Hiatal Hernia
- ❑ Ischemic Bowel
- ❑ Lower GI Bleed
- ❑ Pancreatitis
- ❑ Peptic Ulcer Disease

Hematology:
- ❑ Anemia

Infectious Disease:
- ❑ AIDS
- ❑ Endocarditis
- ❑ Hepatitis
- ❑ HIV
- ❑ Lyme Disease
- ❑ MRSA
- ❑ Pelvic Inflammatory Disease
- ❑ Pneumonia
- ❑ Tuberculosis

Musculoskeletal:
- ❑ Back Pain
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Herniated Disk
- ❑ Lupus
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Spinal Stenosis

Neurologic:
- ❑ Alzheimer's Disease
- ❑ CVA (Stroke)
- ❑ Dementia
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Seizure Disorder
- ❑ Syncope
- ❑ TIA (Mini Stroke)

OBGYN:
- ❑ Gestational Diabetes

Oncology:
- ❑ Cancer: Type_____

Psychiatric:
- ❑ Anorexia
- ❑ Bipolar Disease
- ❑ Bulemia
- ❑ Chronic Anxiety
- ❑ Depression
- ❑ Panic Disorder
- ❑ Post Traumatic Stress Disorder
- ❑ Schizophrenia

Renal/Genitourinary:
- ❑ End Stage Renal Disease
- ❑ Erectile Dysfunction
- ❑ Hematuria
- ❑ Kidney Stones
- ❑ Polycystic Kidneys
- ❑ Renal Artery Stenosis
- ❑ Renal Failure, Acute
- ❑ Renal Insufficiency

Respiratory:
- ❑ Asthma
- ❑ COPD/Emphysema
- ❑ Pneumonia
- ❑ Pulmonary Embolus
- ❑ Pulmonary Hypertension
- ❑ Sleep Apnea
- ❑ Tuberculosis

Skin:
- ❑ Cellulitis

Vascular:
- ❑ Claudication
- ❑ DVT
- ❑ Peripheral Vascular Disease
- ❑ Raynaud's
- ❑ Varicose Veins

Past Surgical History: Please list any surgeries you have had and additional information if possible

Name of Surgery:	Location/Surgeon's Name:	Date:
Example: Appendectomy	*St. John Hospital, Dr. John Smith*	*August, 1990*

Family History:

Family Member:	Age:	Significant Health Problem:	Cause of Death

Patient Name: _____

Cardiac History: Please mark the box and fill in additional information next to any procedures/tests you have had

Name of Procedure/Test:	**Location/Provider's Name:**	**Date:**
❑ Echocardiogram		
❑ MUGA (Multi Gated Acquisition Scan)		
❑ TEE (Transesophageal Echocardiogram)		
❑ 24/48 Hour Holter Monitor		
❑ Cardionet or Event Monitor		
❑ Cardioversion		
❑ Ablation		
❑ Pacemaker Implant		
❑ ICD Implant		
❑ Tilt Table Test		
❑ Heart Catheterization		
❑ Angioplasty/Stent Placement		
❑ Carotid Ultrasound		
❑ ABI (Ankle Brachial Index)		
❑ Peripheral Artery Angiogram		
❑ Peripheral Artery Angioplasty/Stent		
❑ Heart Valve Replacement Surgery		
❑ Treadmill Stress Test		
❑ Nuclear Stress Test		
❑ Stress Echocardiogram		
❑ Cardiac CTA		
❑ Pulmonary Function Test		
❑ Sleep Study		

Review of Systems: Check if you are experiencing any of the symptoms listed below

- ❑ Chest pain, pressure, or tightness
- ❑ Heart palpitations or irregular heart beats
- ❑ Excessive sweating
- ❑ Fainting or the feeling of fainting
- ❑ Shortness of breath while lying flat
- ❑ Waking up at night feeling short of breath
- ❑ Pain in legs while walking
- ❑ Swelling in hands, feet, or ankles
- ❑ Weight gain
- ❑ Weight loss
- ❑ Fevers
- ❑ Fatigue
- ❑ Vision changes
- ❑ Hearing loss
- ❑ Snoring
- ❑ Shortness of breath with rest
- ❑ Shortness of breath with activity
- ❑ Use of multiple pillows at night
- ❑ Nausea
- ❑ Heartburn, reflux, or indigestion
- ❑ Rectal bleeding
- ❑ Blood in urine
- ❑ Frequent urination at night
- ❑ Dizziness
- ❑ Loss of memory
- ❑ Seizures
- ❑ Depression
- ❑ Hallucinations
- ❑ Bleeding easily
- ❑ Bruising easily

MEDICATION LIST

DATE: _____

PATIENT NAME: _____ DOB:_____

MEDICATION NAME	DOSAGE	FREQUENCY

DRUG ALLERGIES: