Scottsdale Endocrinology

Grace Zlaket-Matta, MD F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP, Kelly Hogan, PA

Date:________________

Legal Name First ______________________ MI _____ Last ______________________ Preferred Name ________________

SSN ______________________________ DOB _______________ Sex: ❒Male ❒Female Sex at Birth____

Address _________________________________ Apt # ________ City ______________ State: _______ Zip: __________

Phone: Home ______________________________________ Mobile_______________________________________

Email ____ Organ Donor _______ Living Will _______

Preferred Communication: ❒Phone ❒Email ❒Text Message ❒Online Portal ❒Mail

Employment Status: ❒Student ❒Part-time ❒Full-time ❒Retired ❒Unemployed

Employer Name ____ Occupation: ___________________________________

Marital Status: ❒Single ❒Divorced ❒Separated ❒Married ❒Widowed

Preferred Language: ____________________

Race: ❒Asian ❒Black ❒Native-American ❒Hawaiian/Pacific Islander ❒White/Middle Eastern ❒Two or More Races

Ethnicity: ❒Hispanic ❒Non-Hispanic

Do you have any communication difficulties or special needs? _______________________________________

INSURANCE INFORMATION

Primary Insurance ____ ID ______________ Group # ______________

Cardholder Name ___________________ Relationship to Cardholder _________________

Cardholder DOB _____________

Secondary Insurance ____ ID ______________ Group # ______________

Cardholder Name ___________________ Relationship to Cardholder _________________

Cardholder DOB _____________

Primary Care Physician: ______________________ **Phone:** _________________ **Fax:** ___________________

Referring Physician: __________________________ **Phone:** _________________ **Fax:** ____________________

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale,AZ 85260
P: 480-219-5597 F: 480-219-5547

Notice for Prescription Refills

Please allow us **at least a WEEK, or 7 to 10 days,** to request a REFILL on your medications. Once the refill is placed, allow up to three days for it to be processed by your pharmacy. We will process refills during our business hours and ONLY if you have made it to your previous SCHEDULED appointments. **It is important that you contact the pharmacy well before your prescription runs out to give us time to best help you and other patients.**

Notice for Cancellations

I understand and agree to the following courtesies regarding appointment cancellations:

1. I will cancel my appointment at least **24 hours before the appointment**
2. I agree to pay a **$50 No-Show Fee** if I do not show for any scheduled appointment, ultrasound, or biopsy or if I fail to provide a notice 24 hours before the appointment.
3. My provider will terminate or discharge my services if **I do not cancel or do not show to three scheduled appointments** total.

Termination of Services

Should your provider decide to terminate services with you, we will send you a letter. This letter will explain next steps to assist you in securing an alternative provider and receiving prescription refills for the 30 days past the date the termination letter was sent.

We will ensure you exit our practice with the proper care.

Signature ______________________________________ **Date** _________________

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale,AZ 85260
P: 480-219-5597 F: 480-219-5547

Financial Responsibility

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our policies.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: your health plan coverage has lapsed or expired at the time you receive services, your health plan determines that the services you received are not medically necessary and/or not covered by your insurance plan. We are in contract with every insurance we bill, we are required to follow their fee schedule and policies.

You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any co-pays or other patient responsibility amount at each visit/time of service. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished *after* the visit, we may file a claim with your insurance; and if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount at your time of service, your visit may be rescheduled.

Please sign below that the patient understands the above policies.

Signature ______________________________________ **Date** _________________

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale,AZ 85260
P: 480-219-5597 F: 480-219-5547

Authorization to Release Medical Information to a Provider

I authorize the release of my health information, including my medical records, conditions, and / or treatment at Scottsdale Endocrinology **to the following provider.**

Name: ____

Phone ___________________

Fax _____________________

Specific Medical Records to Release: ___________________________________ Date __________

Radiology Reports: ____ Date __________

Please sign below that the patient agrees with the above authorizations.

Signature ________________________________ Date ________________

Scottsdale Endocrinology

Grace Zlaket-Matta, MD, F.E.A.A
Iyad Syoufi, MD
Emma Reeve, PA, Emily Geiser, NP-C, Kelly Hogan, PA
9336 E Raintree Dr Ste 150 Scottsdale,AZ 85260
P: 480-219-5597 F: 480-219-5547

Authorization to Release Medical Information to Family

I authorize the release of my health information, including my medical records, conditions, and or treatment **to the following person(s) or family:**

Name ________________________________ Relationship to patient ______________Phone _____________

Name ________________________________ Relationship to patient ______________Phone _____________

Name ________________________________ Relationship to patient ______________Phone _____________

❒ I do not authorize to disclose my health information to anyone without my written or verbal consent.

Please note that consent for provider access will expire in 90 days after the signed date above. You affirm that you have given your consent freely, voluntarily, and without coercion. You may revoke this authorization at any time provide you notify us verbally or in writing. You understand that any release which wasn't made prior to revocation of authorization will not constitute a breach of your rights to confidentiality.

Please sign below that the patient agrees with the above authorizations.

Signature ____________________________________ **Date ________________**

Medication and Supplement List

Name:____ Date of Birth: ___/___/___

Preferred Pharmacy Name: ____

PHARMACY Address or Cross Streets:____

For your safety, let the provider or medical assistant know of any changes to your medications or any new medications. It is important that you help us update your medications frequently, including any SUPPLEMENTS you're taking, as they can cause possible adverse side effects together. To avoid dangerous interactions, we need to know **everything** you are taking. Please include any **insulin**, as well.

Prescribed or Supplement Medication

Medication Name	**Strength** (mg, mcg, units, etc.)	**How often?**	**Form or how you take it** (tablet, pen, injection, vial, patch, etc.)

PUMP: Please circle if you use one- Omnipod Dash, Omnipod 5, iLet Bionic, Medtronic 630G, Medtronic 770G, Medtronic 780G, Tandem t:slim, Tandem Mobi, Other-___________

Continuous Glucose Monitor: Please circle if you use one- Eversense, Dexcom G6, Dexcom G7,Freestyle 2, Freestyle 3, Medtronic Guardian 3, Medtronic Guardian 4, Other-_______________

MEDICAL HISTORY

Do you have or have you had any of the following?
Please check all that apply and the approximate date you were diagnosed.

DIAGNOSIS	DATE (month/year)
❐ Diabetes	________________
❐ High Blood Pressure	________________
❐ High Cholesterol ❐ Triglycerides	________________
❐ Heart Attack	________________
❐ Heart Failure	________________
❐ Stroke / TIA	________________
❐ Hyperthyroidism	________________
❐ Hypothyroidism	________________
❐ Thyroid Nodule	________________
❐ Thyroid Cancer	________________
❐ Osteoporosis	________________
❐ High / Low Calcium	________________
❐ Sexual Hormone Deficiency	________________
❐ Cancer	________________
❐ Kidney / Bladder Disease	________________
❐ Eating disorder	________________
❐ Depression/Anxiety	________________
❐ Other Medical Problems:	
❐ A-Fibb	
❐ History of Blood clots	
❐ Fracture	
______________________________	________________
______________________________	________________
______________________________	________________
______________________________	________________

ALLERGIES

❐ No Known Drug Allergies

Please list any allergies to drugs, foods, or supplements

____________________ ____________________

____________________ ____________________

____________________ ____________________

FAMILY HISTORY

Do either of your parents, to the best of your knowledge, suffer or have suffered from any of the following conditions?

Please check all that apply and specify which parent.

DIAGNOSIS	FAMILY MEMBER
❐ Diabetes	________________
❐ High Blood Pressure	________________
❐ High Cholesterol ❐ Triglycerides	________________
❐ Heart Attack	________________
❐ Heart Failure	________________
❐ Stroke / TIA	________________
❐ Hyperthyroidism	________________
❐ Hypothyroidism	________________
❐ Thyroid Nodule	________________
❐ Thyroid Cancer	________________
❐ Osteoporosis	________________
❐ High / Low Calcium	________________
❐ Cancer	________________
❐ Eating disorder	________________
❐ Sexual Hormone Deficiency	________________
❐ Eating disorder	________________
❐ Other Medical Problems:	
❐ CKD	
______________________________	________________
______________________________	________________
______________________________	________________
______________________________	________________
______________________________	________________

Please indicate here if your parents are deceased.

❐ Mother ❐ Father

❐ Unknown ❐ Adopted

Scottsdale Endocrinology

PAST SURGERIES

List any surgeries you've had as well as the approximate date they took place.

SURGERY	DATE (month/year)
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________
____________________	____________

RECENT HOSPITALIZATIONS

List any recent hospitalizations. Include the reason for the visit and the approximate date they took place.

____________________ ____________

____________________ ____________

____________________ ____________

____________________ ____________

____________________ ____________

____________________ ____________

PERSONAL HABITS

Do you use tobacco? ❒Yes ❒No

If so, how much and how often? ______________________

Are you an ex-smoker? ❒Yes ❒No

What year did you stop? ______________________

Do you use alcohol? ❒Yes ❒No

If so, how much per week/per month? ______________________

Do you use any recreational drugs? ❒Yes ❒No

DIABETIC PATIENTS ONLY

Please fill out this section if you have been diagnosed with diabetes or prediabetes.

Year diagnosed ____________

List any DIABETIC medications you've tried and when you stopped:

MEDICATION	DATE OF CESSATION
____________	____________________
____________	____________________
____________	____________________
____________	____________________

How many times a day do you test your blood sugar?

____

Name of insulin pump ______________________

Name of blood sugar meter ______________________

Name of test strips ______________________

Name of your cardiologist and your last appointment date:

____________________ ____________

❒ I don't have a cardiologist

Name of your eye doctor and your last appointment date:

____________________ ____________

❒ I don't have an eye doctor

Name of your podiatrist and your last appointment date:

____________________ ____________

❒ I don't have a podiatrist

Did you get a flu shot this season?

❒ Yes ❒ No