my Medical Makeover

Male Hormone Patient Information Form

Name: ______________________________

DOB: ________/________/________

What are you seeing the doctor for today?

____

____

____

When did you first notice the symptoms?

____

____

____

Male Personal History:

Are you currently sexually active? ☐ Yes ☐ No

Is your sex drive similar as it was 5 years ago?
☐ Yes ☐ No Describe: ______________

Do you have erectile dysfunction? ☐ Yes ☐ No

Have you fathered any children? ☐ Yes ☐ No

If yes, how many? ______________

Have you had any sexually transmitted diseases?
☐ Yes ☐ No Describe: ______________

Are you HIV positive? ☐ Yes ☐ No

If yes, when did this occur? ______________

Treatment? ______________

Do you have prostate problems? ☐ Yes ☐ No

If yes, describe: ______________

Have you ever had prostate or testicular cancer?
☐ Yes ☐ No Describe: ______________

Treatment? ______________

Have you ever had any form of cancer?
☐ Yes ☐ No Type: ______________

Have you had testosterone levels taken in the past?
☐ Yes ☐ No When? ______________

Are you using any form of Testosterone or Hormone Therapy? ☐ Yes ☐ No
☐ Gel ☐ Cream ☐ Shots ☐ Pellets
☐ Other: ______________

Experienced any weight gain or loss in last 1-2 years? ☐ Yes ☐ No Describe: ______________

Are you suffering from any of the following?

Decrease in energy level:	☐ Yes ☐ No
Decrease in sexual desire:	☐ Yes ☐ No
Fatigue:	☐ Yes ☐ No
Foggy thinking:	☐ Yes ☐ No
Irritability:	☐ Yes ☐ No
Loss of well-being	☐ Yes ☐ No
Memory loss:	☐ Yes ☐ No
Mood swings:	☐ Yes ☐ No
Muscle loss:	☐ Yes ☐ No
Poor recovery from exercise:	☐ Yes ☐ No
Poor response to exercise:	☐ Yes ☐ No
Sleep problems:	☐ Yes ☐ No

Medical History

Do you have or ever had any of the following?

	Yes	No	History of
Anemia/Bleeding disorder:	☐	☐	☐
Anesthesia complications:	☐	☐	☐
Describe: ______________			
Arthritis:	☐	☐	☐
Type: ______________			
Asthma:	☐	☐	☐
Blood clots:	☐	☐	☐
Crohn's/Colitis	☐	☐	☐
Diabetes:	☐	☐	☐
Emphysema/Bronchitis:	☐	☐	☐
GERD (reflux)	☐	☐	☐
Heart attack or stroke:	☐	☐	☐
Heart disease:	☐	☐	☐
Hepatitis:	☐	☐	☐
Type: ______________			
High Cholesterol:	☐	☐	☐
Hypertension:	☐	☐	☐
IBS	☐	☐	☐
Kidney disease:	☐	☐	☐
Liver disease:	☐	☐	☐
Lung disease:	☐	☐	☐
Lupus/Scleroderma:	☐	☐	☐
Major accidents:	☐	☐	☐
Describe: ______________			
Polyps- Colon	☐	☐	☐
Psychiatric disorder:	☐	☐	☐
Describe: ______________			
Thyroid problems:	☐	☐	☐
Type: ☐low function	☐overactive	☐goiter	☐hashimoto
Varicose veins:	☐	☐	☐

Other: ______________

____

____

Reviewed by: ______________

Date: ______________

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Financial Acknowledgement and Insurance Information
Male Hormone Pellet Insertion

Bio-identical hormone replacement pellet therapy is typically recognized by insurance carriers as a reimbursable procedure for males due to medical necessity. We do, however, collect fees for hormone pellet insertion upfront on the day of insertion. We will still file claims for these services on your behalf to your insurance company. Once your insurance carrier has remitted payment to us, a refund check will be issued to you for any over payment you made on the day of insertion. *Our billing/insurance coordinator is available to answer any questions you have in regards to the upfront cost vs. what is filed to your insurance company.*

I, ______________________________, hereby certify that I am eligible for
(Patient Name)

insurance coverage with ______________________________.
(Name of Insurance Carrier)

Subscriber Name: ______________________ DOB: ____________
Policy Contract # or ID #: ______________________
Group #: ____________________ Effective Date: ____________
Claim Address: ______________________
City: ____________________ State: ________ Zip: ________
Phone: ______________________

I understand Family Practice at The Falls will file insertion claims to my insurance carrier on my behalf, although this is not a guarantee of payment. I agree to pay in full all insertion related expenses at the time of service and any remaining balance left on my account after payment is remitted by my insurance carrier. <u>I also understand that payment on the day of insertion is to be paid with cash or credit card prior to insertion of pellets.</u>

______________________ Patient Name (Printed)

______________________ Date of Birth

______________________ Patient Signature

______________________ Today's Date