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Female New Patient Package

Thank you for your interest in Hormone Replacement Therapy Pellets at Martel Medical Office, Inc. Please take the time to carefully read through the following packet. Please answer all questions as thoroughly as possible.

In addition to the medical history contained within this packet, we require that all patients have a current & comprehensive lab panel drawn. These two items, along with the information gathered during your consultation, will be used to determine whether you are a candidate for Hormone Replacement Therapy Pellets. We look forward to helping you achieve your optimal hormone health.

Please print, complete, and bring these forms with you to your scheduled appointment. You may also email completed forms to martelmedicaloffice@yahoo.com.

FEMALE QUESTIONNAIRE & HISTORY

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): Married Divorced Widow Single

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below, you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

- I am sexually active.
- I want to be sexually active.
- I have completed my family.
- My sex has suffered.
- I haven't been able to orgasm.

Habits:

- I smoke cigarettes or cigars. _____ per day
- I drink alcoholic beverages. _____ per day
- I drink more than 10 alcoholic beverage per week.
- I use caffeine _____ per day.

MEDICAL HISTORY

Any known drug allergies: _____

Have you ever had any issues with anesthesia? () Yes () No

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

- () Medical Exam in the last year.
- () Mammogram in the last year.
- () Bone Density in the last year.

Past Medical/Surgical History:

- () Breast Cancer
- () Uterine Cancer
- () Ovarian Cancer
- () Partial Hysterectomy
- () Full Hysterectomy
- () Removal of Ovaries

Birth Control Method:

- () Hysterectomy
- () Birth Control Pills
- () Vasectomy
- () Other: _____

Medical Illnesses:

- () High blood pressure
- () Heart bypass
- () High cholesterol
- () Hypertension
- () Heart Disease
- () Stroke and/or Heart Attack
- () Blood clots
- () Pulmonary Embolism
- () Arrhythmia
- () Hepatitis or HIV
- () Lupus
- () Fibromyalgia
- () Diabetes
- () Thyroid Disease
- () Arthritis
- () Depression/Anxiety
- () Psychiatric Disorder

BHRT Checklist For Women

Name: _____ **Date:** _____

Email: _____

Symptom (please mark)	Never	Mild	Moderate	Severe
Depressive Mood				
Memory Loss				
Mental Confusion				
Decreased Sex Drive/Libido				
Difficult to Climax Sexually				
Difficulty Falling Asleep				
Difficulty Staying Asleep				
Irritability				
Tension				
Migraines/Severe Headaches				
Bloating				
Weight Gain				
Bloating				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry & Wrinkles Skin				
Hair Loss				
Difficulty Regulating Temperature				
Joint Pain				

Family History:

CONDITION:	YES	NO	DETAILS
Heart Disease			
Diabetes			
Osteoporosis			
Alzheimer's Disease			
Cancer			

HORMONE REPLACEMENT THERAPY FEE ACKNOWLEDGEMENT

Preventative medicine within bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though Monique Martel is board certified as a Nurse Practitioner, insurance does not recognize this procedure as medically necessary. That being said, Hormone Replacement Therapy Pellets are not covered by health insurance companies.

Martel Medical Office, Inc. is not associated with any insurance companies for this procedure, which means they are not obligated to pay for any affiliated services including consultations, blood work, and insertions. We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

Your super bill and receipt from the date of service are your responsibility and serve as evidence of your treatment. **We will not call, write, pre-certify, or make any contact with your insurance company.** Any follow up letters from your insurance to us will be disregarded. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

Patients who have access to a Health Savings Account may pay for his or her treatment with that credit or debit card. Those who do not have an HSA as part of their insurance plan are responsible for payment of the consultation, blood work, and insertions at the time of the visit. Please see the fee schedule as follows:

NEW PATIENT CONSULTATION: **\$125.00**

INITIAL LAB PANEL: **\$190.00**

FOLLOW-UP LAB PANEL: **\$70.00**

FEMALE PELLETT INSERTION: **\$325.00**

MALE PELLETT INSERTION <2000mg: **\$600.00**

MALE PELLETT INSERTION >2000mg: **\$700.00**

Payment is due at the time of service. We accept all major credit cards, cash, and checks.

First Name: _____ Last Name: _____

Signature: _____ Date: _____

Please notify the receptionist if you would like a copy of this signed agreement for your records.