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Male 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.

MALE 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 mean's 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 have used steroids in the past for athletic purposes.

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: ___

Other Pertinent Information: ___

Medical Illnesses:

( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart Disease
( ) Stroke and/or Heart Attack
( ) Blood clots
( ) Pulmonary Embolism
( ) Arrhythmia
( ) Hemochromatosis
( ) Hepatitis or HIV
( ) Lupus
( ) Fibromyalgia
( ) Diabetes
( ) Thyroid Disease
( ) Arthritis
( ) Depression/Anxiety
( ) Psychiatric Disorder
( ) Testicular or Prostate Cancer
( ) Elevated PSA
( ) Prostate Enlargment

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Signature: ___ Date: ___

BHRT Checklist For Men

Name: ______________________________ **Date:** ____________________

Email:____

Symptom (please mark)	Never	Mild	Moderate	Severe
Decline in General Well Being				
Joint Pain or Muscle Ache				
Excessive Sweating				
Decreased Sex Drive/Libido				
Increased Need for Sleep				
Difficulty Falling Asleep				
Difficulty Staying Asleep				
Irritability				
Nervousness				
Anxiety				
Depressed Mood				
Exhaustion / Lacking Vitality				
Declining Mental Ability or Concentration				
Decreased Muscle Strength				
Inability to Lose Weight				
Breast Development				
Decreased Morning Erections				
Decreased Ability to Perform Sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				
Feeling Burned Out				

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 PELLET INSERTION: **$325.00**
MALE PELLET INSERTION <2000mg: **$600.00**
MALE PELLET 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.