Patient Information

Name of Patient: ____ Date: _________________

(last) (first) (middle)

Mailing Address: ____

City: ____________________________ State: ________________________ Zip Code: ___________________

Phone: Home: ______________________ Cell: ________________________ Other ______________________

PREFERED CONFIRMATION METHOD: □ **TEXT** □ **EMAIL** □ **PHONE CALL**

E-Mail Address: __________________________________ Social Security #:____________________________

Date of Birth: _______________________ Marital Status: □ Single □ Married □ Other

Occupation: ____________________ Employer: ______________________ Work Phone: _______________

Reason for Visit: ____

Work Injury: Yes_____ No_____ **If yes, date of injury** ____

Emergency Contact Name: _________________ Relationship: ________________ Phone: ______________

What information can we share: □ Health Information □ Billing □ Other

List family members, physicians or persons (including phone #) whom we may inform about your medical condition:
____

Who can we thank for referring you: ____

May we use your name when thanking them? (if applicable, please circle): YES or NO

CANCELLATION POLICY

Please arrive 15 minutes prior to your scheduled appointment time. This will allow enough time to fill out and update any needed forms and begin your appointment as close to the scheduled start time as possible. A late arrival may result in the need to reschedule your appointment so that we may best serve you as well as the other clients that day. We ask that you please make any changes to your appointment no less than 24 hours prior to your appointment to avoid any cancellation fees.

Patients who no-call/no-show their appointments may be subject to cancellation fees.

I understand that I am responsible for the payment of all services rendered and I agree to follow the established credit policy of this office.

PATIENT SIGNATURE: ____ DATE: _______________

HIPPA NOTICE OF PRIVACY POLICY

I, _________________________________, understand Dr. Charles P. Virden's Notice of Privacy Policy (HIPAA) and hereby □ request □ decline a copy for my personal records.

PATIENT SIGNATURE: ____ DATE: _____________

PATIENT HISTORY & PHYSICAL

PATIENT HISTORY

NAME: ____DOB: ____________ AGE: ______ HT: ______ WT: ______

ALLERGIES: ____

PREVIOUS SURGERIES: ____

Anesthesia Problems: Yes No

Heart Problems: Yes No

High Blood Pressure: Yes No

Stroke/Circulatory Problems: Yes No

Bleeding Problems: Yes No

Breathing problems: Yes No

Seizures or Epilepsy: Yes No

Pregnant: Yes No

Diabetes: Yes No

Kidney Problems: Yes No

Cancer: Yes No

Liver Problems: Yes No

Thyroid Problems: Yes No

Digestive Problems: Yes No

Visual or Hearing Problems: Yes No

Hepatitis: Yes No Type: - __________

Chronic Pain: Yes No Location: _______

Do You Smoke? Yes No Amount? _______

History of: ESBL MRSA C. diff VRE N/A

List Current Medications and Supplements: ____

____

Personal Physician: ___________________________________ Referring Physician: _________________________________

Patient Signature: ____ Date: ________________ Time: _______________

PHYSICIAN'S PHYSICAL EXAMINATION

HEENT WNL □

NECK WNL □

LUNGS WNL □

HEART WNL □

BREAST WNL □

ABDOMEN WNL □

GU WNL □

RECTAL WNL □

NEURO WNL □

EXTREMEMTIES WNL □

NOTES:____

____

____

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____

____

IMPRESSION/DIAGNOSIS: ____

PLAN: ____

____

PHYSICIAN SIGNATURE: ____________________________________M.D. Date: _________________ Time:_____________

NURSE'S NOTES

BP:_________P:______ R:______ HEART & LUNGS CLEAR TO AUSCULTATION: YES NO PHOTOS TAKEN: YES NO

LABS ORDERED: CBC UA CHEM PANEL BUN CREAT LYTES BS PT/PTT AUTO-BLD CXR EKG

PRE & POST-OP INSTRUCTIONS REVIEWED: □ VERBAL WRITTEN

SURGERY FACILITY: ____ DATE: ________________ TIME: ______________

Rx TO PATIENT: ____

PATIENT POST-OP DRIVER & PHONE #: ____________________________________ PATIENT POST-OP PHONE #: ___________________

NOTES: ____

NURSE SIGNATURE: ______________________________________R.N.________________ Date: ________________ Time: ___________

Hormone Replacement Fee Acknowledgement

Therapellet hormone replacement is safe and effective, but still not recognized by insurance companies as "alternative" medicine. Despite your treatment being overseen by our Board Certified Physcian, Physician Assistant, and/or Nurse Practitioner, insurance does not recognize it as necessary medicine, and thus not covered by most insurance companies. You are obligated to pay for our services (blood work, consultations, or insertions) at the time of service. 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 communicate in any way with your insurance company.

Consultation Fee*……………………………………………………………………..$150
Lab fee: ……………………………………………………………………………$250**
Female Hormone Pellet Insertion Fee*………………………………………. $350**
Male Hormone Pellet Insertion Fee*…………………………………………. $750**

We accept the following forms of payment:
Master Card, Visa, Discover, American Express, Care Credit, Personal Checks and Cash.

*Consult fees are not applied to pellet insertion, if at your consult you also receive pellet insertion there will be a charge for the consult and pellet insertion. The consult fee is a one time fee to establish you with our practice and a medical practitioner.

**Labwork is required pre-consult to determine if you are a candidate for pellets, if you are a candidate you will have to get another set of labs done post pellet insertion and there will be an additional charge for post labs (males at 4 weeks post insertion and women at 6 weeks post insertion).

***Hormone pellets will need to be inserted multiple times a year and there is a fee for each insertion.

Patient Name (Print): ____

Signature: ____ Date: __________

Charles P. Virden, M.D., F.A.C.S.
960 Caughlin Crossing N. Suite 100 Reno, NV 89519
Phone: 775-348-9798 Fax: 775-348-5809
www.therapellet.com

Male New Patient Information

Thank you for your interest in Bio-Identical Hormone Therapy. This is your first step to restore your vitality. In order to determine if you are a candidate for bio- identical hormone replacement, we need laboratory results from you.

We will evaluate your information prior to your consultation to determine if Bio-Identical Hormone Therapy can help you live a healthier life. **Please complete the following tasks before your appointment:**

2 weeks or more before your scheduled consultation: Get your blood drawn at the laboratory of your choice (ex: Quest Laboratory or LabCorp). We request the tests listed below. It is your responsibility to find out if your insurance company will cover the cost, and which lab to go to.

***IF YOU ARE NOT INSURED OR HAVE A HIGH DEDUCTIBLE, YOU CAN PAY OUR OFFICE $250 which will cover your initial blood panel and post pellet panel. Please note that it can take up to two weeks for your lab results to be received by our office.**

Your blood work panel MUST include the following tests:

Estradiol
Testosterone, Total
PSA Total
TSH
T4, Total
T3, Free
T.P.O. Thyroid Peroxidase
CBC (optional)
Complete Metabolic Panel (optional)
Vitamin D, 25-Hydroxy

Male Post Insertion Labs Needed at 4 Weeks:

Estradiol
Testosterone, Total
PSA Total (If PSA was borderline on first insertion)
CBC (optional)
TSH, T4 Total, T3 Free, TPO (**Only needed if you've been prescribed thyroid medication**)

We look forward to seeing you for your appointment on:___________________________________

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Male Patient Questionnaire & History

Habits:

( ) I smoke cigarettes or cigars____________ a day.
( ) I drink alcoholic beverages_________ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine______________ a day.

Medical History (if not listed on H&P)

Current Hormone Replacement Therapy:____

Past Hormone Replacement Therapy:____

Nutritional/Vitamin Supplements:____

History of Steroid use for Athletic purposes: **YES** **NO**

Other Pertinent Information:____

Medical Illnesses:

( ) High blood pressure.
( ) High cholesterol.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Hemochromatosis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type): ___________________
Year: _________________

( ) Testicular or prostate cancer.
( ) Elevated PSA.
( ) Prostate enlargement.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.

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Male Patient Symptom Checklist

Please check all of your symptoms and indicate severity.

Symptom	Never	Mild	Moderate	Severe
Decline in Overall Well Being				
Fatigue				
Memory Loss				
Joint Pain/Muscle Ache				
Decreased Sex Drive/Libido				
Sleep Problems				
Mood Changes				
Irritability				
Nervousness/Anxiety				
Feeling Burned Out				
Migraines/Headaches				
Difficulty Concentrating				
Decreased Muscle Strength				
Weight Gain/Increased Belly Fat				
Breast Development				
Shrinking Testicles				
Decreased Morning Erections				
Night Sweats				
Dry and/or Wrinkled Skin				
Rapid Hair Loss				
Infrequent or Absent Ejaculation				
No Result from ED Medications				
Excessive Sweating				

0=Never 1=Mild 2=Moderate 4=Severe

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