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	Liver Problems:	Yes	No
Heart Problems:	Yes	No	Thyroid Problems:	Yes	No
High Blood Pressure:	Yes	No	Digestive Problems:	Yes	No
Stroke/Circulatory Problems:	Yes	No	Visual or Hearing Problems:	Yes	No
Bleeding Problems:	Yes	No	Hepatitis:	Yes	No Type: - _____
Breathing problems:	Yes	No			
Seizures or Epilepsy:	Yes	No	Chronic Pain:	Yes	No Location: _____
Pregnant:	Yes	No			
Diabetes:	Yes	No	Do You Smoke?	Yes	No Amount? _____
Kidney Problems:	Yes	No			
Cancer:	Yes	No	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	☐	NOTES: _____
NECK	WNL	☐	_____
LUNGS	WNL	☐	_____
HEART	WNL	☐	_____
BREAST	WNL	☐	_____
ABDOMEN	WNL	☐	_____
GU	WNL	☐	_____
RECTAL	WNL	☐	_____
NEURO	WNL	☐	_____
EXTREMEMTIES	WNL	☐	

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

Female 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
FSH
Testosterone, Total
TSH
T4, Total
T3, Free
T.P.O. Thyroid Peroxidase
Vitamin D, 25-Hydroxy
Vitamin B12
CBC (optional)
CMP (optional)

Female Post Insertion Labs Needed at 6 weeks:

FSH
Testosterone, Total
Estradiol
TSH, T4 Total, T3 Free (**Needed only if you've been prescribed thyroid medication at visit)**

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

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

Female 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:_____

Last menstrual cycle (estimate year if unknown):

_____

Other Pertinent Information:_____

Preventative Medical Care:

Date of last pap smear:_____
Date of last Mammogram:_____
Date of last Bone Density:_____

Do you have a history of:

( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) None of Above

Have you had:

( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy (removal of uterus only)
( ) Oophorectomy (Removal of Ovaries only)

Birth Control Method:

( ) Menopause.
( ) Hysterectomy.
( ) Tubal Ligation.
( ) Birth Control Pills.
( ) Vasectomy.
( ) Other:_____

Please mark any **Medical Illnesses:**

( ) High blood pressure.
( ) Heart bypass.
( ) High cholesterol.
( ) Hypertension.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Arrhythmia.
( ) Any form of Hepatitis or HIV.
( ) Lupus or other auto immune disease.
( ) Fibromyalgia.
( ) Trouble passing urine or take Flomax Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer (type):_____Year:_____

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

Female Patient Symptom Checklist

Please check all of your symptoms and indicate severity.
0=Never 1=Mild 2=Moderate 4=Severe

Symptom	Never	Mild	Moderate	Severe
Depressive Mood				
Fatigue				
Memory Loss				
Mental Confusion				
Decreased Sex Drive/Libido				
Sleep Problems				
Mood Changes				
Irritability				
Tension				
Migraines/Headaches				
Difficult to Climax Sexually				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry and/or Wrinkled Skin				
Hair Loss				
Sensitivity to Cold				
Swelling				
Joint Pain				

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