FREEDOM
HEALTHCARE
HORMONES & WELLNESS

DEMOGRAPHIC FORM

(Male insurance patient)

PT NAME:_____GENDER: **M** or **F**

Date of birth:____/_____/_____ PHONE #:_____

ADDRESS:_____City:_____State:_____ZIP:_____

EMAIL:_____

SSN:_____ EMERGENCY CONTACT:_____PH:_____

PHARMACY NAME:_____ PHONE #:_____

EMPLOYED BY:_____

Please fill out the information below if you carry an insurance policy. Please note Freedom Healthcare does not accept all insurances

*PLEASE NOTE THAT IT IS THE **PATIENT'S RESPONSIBILITY** TO KNOW COVERAGE DETERMINATION, DEDUCTIBLES, AND COPAYS FOR USING INSURANCE FOR ANY SERVICES*

Name of Insurance:_____ Policy Holder:_____

DOB:_____ Relation:_____

Policy Holder Address (if different from patient):

Street:_____City:_____State:_____ZIP:_____

ID Number:_____ Group #:_____

Insurance Phone Number:_____ __Address:_____

PATIENT HEALTH AND LIFESTYLE QUESTIONNAIRE (MALE)

Please ask any questions you may have about Natural Hormone Replacement Therapy, other medication, nutritional supplements, or any other questions that may come up as you are reading through the materials that you have received.

Lifestyle Information

Marital Status:_____ Level of Education:_____

Any children? If so how many?_____

Do you use tobacco (smoke, chew)?_____ If so, how much and how often?_____

Do you drink alcohol?_____ If so, how much and how often?_____

Do you drink caffeine?_____ If so , how much and how often?_____

Have you or are you using any illicit drugs?_____ If so, what?_____

Do you exercise regularly?_____ If so, how much and how often?_____

Do you practice any stress management techniques?_____

Occupation:_____

***Referred by:_____

Medical History

Please list any medical problems that other medical practitioners have diagnosed: (i.e Heart disease, high blood pressure, blood clots, stroke, liver or kidney problems, diabetes, epilepsy, fibromyalgia, chronic fatigue syndrome, gallstones, depression, hypothyroidism, cancers.)

_____

_____

_____

Past Surgeries or

Hospitalizations:_____

_____

_____

_____

Do you have treated or untreated high blood pressure?_____

Have you ever had a blood transfusion?_____

Have you ever had a significant head injury?_____

Have you ever had a blood clot of the lower legs, or lung?_____

Do you usually get up to urinate during the night?_____

Any pain with urination?_____ Any blood with urination?_____

Has force of your urinary stream declined?_____

Any testicular pain or swelling?_____

Tests

Have you ever had any of the following tests performed? Check those that apply, and note the date of when the last test was performed.

Prostate Exam:_____ Date and Result:_____

PSA Blood Test:_____ Date and Result:_____

Bone Density Scan:_____ Date and Result:_____

Any blood work done within the last year and where it was performed?_____

Family History

Do you have any of the following medical conditions in your immediate family?

Heart Disease:_____ Relationship:_____

Osteoporosis:_____ Relationship:_____

Cancer:_____ What type:_____ Relationship:_____

Blood Clots:_____ Relationship:_____

Diabetes:_____ Relationship:_____

Medications

Any allergies to drug medications?_____

Please list all prescription medications and dose:

Name:	Strength:	How many times a day:

Please list all nutritional/natural supplements that you are using:

Name:	Strength:	How many times a day?

Please rate the following symptoms:

0= Never a problem, 1= Mild, 2= Moderate, 3= This is serious for me

	Constipation		Memory Loss
	Difficulty Sleeping		Low erection quality/can't maintain an erection

	Joint/body pains		Anxiety
	Moodiness/Irritability		Weight gain
	Weight loss		Headaches/Migraines
	Difficulty concentrating		Increased body or facial hair
	Low ejaculate volume		Sugar/food cravings
	Dry hair/skin		Loss of Motivation
	Unable to reach orgasm		Fatigue
	Loss of hair		Acne/oily skin
	Low libido		Loss of muscle mass
	Inability to ejaculate		Feeling of depression

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I, _____ do hereby acknowledge that I agree to the use of
(Print First and Last Name)

BHRT (bioidentical hormone replacement therapy)as prescribed by _____.
(Print Provider Name Title)

Additionally, I am aware that the use of any anabolic steroid(s) and the use of testosterone cypionate or any other form of testosterone use with an anabolic steroid(s) is prohibited. Furthermore, I am aware that should I choose to use an a(n) anabolic steroid(s) with any of the prescribed BHRT therapies, treatment will be immediately terminated and I will be discharged from the care of the above mentioned provider. I am aware that the risks of anabolic(s) steroid(s) include: J Sports Sci Med. 2006 Jun; 5(2): 182–193.:

Cardiovascular
- ■ Lipid profile changes
- ■ Elevated blood pressure
- ■ Decreased myocardial function

Dermatological
- ■ Acne
- ■ Male pattern baldness

Endocrine
- ■ Gynecomastia
- ■ Decreased sperm count
- ■ Testicular atrophy
- ■ Impotence and transient infertility

Hepatic
- ■ Increased risk of liver tumors and liver damage

Genitourinary
Males
- ■ Reduced sperm counts
- ■ Decreased testicular size

Females
- ■ Menstrual irregularities
- ■ Clitoromegaly
- ■ masculinization

Males and Females
- ■ Gynecomastia
- ■ Libido changes

Musculoskeletal
- ■ Premature epiphyseal plate closure
- ■ Increased risk of tendon tears
- ■ Intramuscular abscess

Psychological
- ■ Mania
- ■ Depression
- ■ Aggression
- ■ Mood swings

I do hereby release Freedom Healthcare and Preventative Medicine of Utah from any liability for any ADVERSE REACTION AND/OR HEALTH RISKS associated with my failure to comply with the providers above recommendations.

_____ _____

(Patient Signature) (Date)

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Agreement for Hormone Replacement

The patient specifically authorizes Freedom Healthcare/PMU to perform an evaluation, develop, and suggest a plan for optimal health. The patient warrants that all information that they have submitted for this evaluation is true to the best of their knowledge. The patient has requested and consents to the administration of hormones and/or oral supplements and authorizes that these will be prescribed by any provider of Freedom Healthcare/Preventative Medicine. The patient acknowledges that there are no guarantees or promises made with respect to how well they will benefit from the hormone supplementation therapy prescribed for them.

The patient understands that initial blood tests will be performed to establish their baseline hormone levels. They agree to comply with reasonable requests for follow up testing to assure proper monitoring of hormone levels. Patient agrees to report to us any adverse reaction or problem that might be related to their hormone therapy. The patient agrees to communicate about their healthcare through emails, text messages, in office consultations, and phone calls.

The patient understands that with hormone supplementation there are possible risks and complications if they do not comply with the recommended dosages. As a patient I understand that I will be in charge of administering the hormones and supplements prescribed to me; therefore the patient will conform and comply with the recommended dosages and methods of administration. They understand that the role of the providers within Preventative Medicine/ Freedom Healthcare is for the management of their Freedom Healthcare/PMU health plan and hormone replacement. Patient understands that they may need to be under the care of another health care provider for any or all of their other medical conditions, should they choose.

The patient understands that they are responsible for payment of services rendered. The patient therefore agrees to pay for all services essential to hormone therapy including maintaining prescriptions, labwork, draw fee's, testing, and the cost of prescriptions with the understanding that they may not be reimbursed by Insurance or Freedom Healtcare/PMU for professional fees, laboratory, medical costs, and pharmacy charges.

Please be advised, a $25 late cancelation or no show fee will be applied if the appointment is not cancelled within 24 hours prior to your appointment.

By signing below I agree to pay all amounts owed within 30 days of when such amounts are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past due amounts at the rate of 18% per annum 1.5% per month until paid in full. In the event any amount is referred to a third party debt collection agency, I agree that in addition to any other amount allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 33.33% of the principal amount owing as allowed by Utah Code.

Patient Print Name:_____

Patient Signature:_____ Date:_____

Aaron Butcher, PA-C / Service of Jeff Nelson, D.O.

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