MediTouch Upload & Update
Entered By:_____
Date:_____

2017

Patient Information

Patient Name:_____ Date of Birth: _____/_____/_____ Gender: M / F

Address: _____ Apt,Suite,Unit#:_____

City: _____ State:_____ ZIP:_____

Home#:(_____)_____-_____Work#:(_____)_____-_____Cell#:(_____)_____-_____

Occupation: _____ Referred By:_____

Email:_____ Marital Status: Single / Married / Divorced / Widowed

Are you currently covered by health insurance? **Yes / No**

Insurance Company:_____

Subscriber/Policy ID#:_____ Group#:_____

Are you the Primary Insured, Policy Holder? **Yes / No**
(If you answered No; please fill out the Policy Holder's information)

Policyholder's Name:_____ Policy Holder's Date of Birth: _____/_____/_____

******PLEASE ALLOW OUR STAFF TO MAKE A COPY OF YOUR DRIVERS LICENSE & INSURANCE CARD******

Release of Medical Information

I _____, give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members listed below.

Name of Authorized Individuals	Relationship to Patient	Date of Birth
_____	_____	___/___/____
_____	_____	___/___/____
_____	_____	___/___/____

_____ _____ ____/____/_____

Printed Name Signature Date

Patient Responsibility & Assignment of Benefits

Our practice is committed to providing you with the best possible health care. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions or concerns about our fees, or any content written in our Financial Policy below.

As a courtesy, we will submit claims for all services rendered to your insurance company. Please note your individual health insurance policy is a contract between you and your insurance company, and we cannot guarantee benefit coverage and/or payment. Coverage is based on medical necessity, plan limitations, and guidelines. Please keep in mind that some of our services may not be covered by your insurances policy. By providing for care, you agree that you are responsible for all services and charges, regardless of your insurance.

While providing care for your medical needs certain tests and/or services are necessary for diagnosis, treatment, and maintenance of good health. All lab work performed in our office will be sent to LabCorp or Sonora Quest, and billed to your insurance. If these tests and/or services are not covered by your health insurance; you may receive a separate bill from LabCorp or Sonora Quest for those services rendered.

It is important that you understand that you are responsible for all charges that may occur during your visit. In addition to paying for any insurance co-payment, co-insurance, or deductible balances at the time of service, you may also be responsible for services not covered by your insurance carrier. Insurance companies may set certain guidelines and/or limitations, understand it is your responsibility to abide by the guidelines set by your individual insurance policy. If your insurance carrier denies the medical claim, the patient is responsible for timely payment of the account.

Cancellation & Late Fees

A **24 hour** notice is required if you are unable to keep your appointment. Missed appointments and appointments not cancelled within a 24 hour notice will be subject to **a fee of $50.00** and must be paid before you are able to be rescheduled. _____ (initial)

If you are more than **15 minutes** late for your scheduled appointment (other than weekly TRT visits) and fail to call informing the practice in advance you will be subject to a late **fee of $25.00.** _____ (initial)

I have read the financial policy for the practice and understand that I am responsible for all charges on my account. It is my financial responsibility to supply payment for any charges not covered by my insurance plan including, but not limited to co-insurance, co-payments, and deductibles. I understand that co-payments for the office are due at the time of service.

_____ __/__/____

Printed Name Date

_____

Signature

Health History Form

Your answers to this form will help your healthcare providers better understand your medical concerns and conditions.

Name_____Date of Birth_____Age_____Todays Date_____

PAST MEDICAL HISTORY

Medical Problems/Hospitalizations (i.e. diabetes, cancer high blood pressure, high cholesterol, depression, etc)	**Surgical History** (i.e. tonsillectomy, appendectomy, hernia, hysterectomy, colonoscopy, etc.) include month/year

FAMILY MEDICAL HISTORY

Father ☐Living, Any Medical Conditions:_____

☐Deceased, cause of death:_____

Mother ☐Living, Any Medical Conditions:_____

☐Deceased, cause of death:_____

Brothers____# ☐Living, Any Medical Conditions:_____

☐Deceased, cause of death:_____

Sisters ____# ☐Living, Any Medical Conditions:_____

☐Deceased, cause of death:_____

Specific Illness in Family History: (i.e. colon ca, breast ca, prostate ca, heart disease, stroke, etc.) ☐None
If so, please state disease and who?_____

SOCIAL HISTORY

Tobacco Use: ☐ Never ☐ Former ☐ Current ____#Packs/Day ____#Years Stopped Smoking Date: _____

Alcohol: ☐ None ☐ Rarely ☐ Social ☐ 1-2 drinks/day ☐ greater than 2 drinks/day ☐ greater than 6 drinks/day

Is your alcohol use a concern for you or others? ☐ No ☐ Yes

Illicit Drug Use: ☐ Never ☐ Former ☐ Current: _____ Stopped Use Date:_____

Caffeine Use: ☐ None ☐ Coffee ☐ Tea ☐ Soda _____# cups/day

Education: ☐ High School ☐ Some College ☐ Degree (s) _____

Occupation: _____ ☐ Retired, _____Year

Marital Status: ☐ Single ☐ Married _____years ☐ Divorced ☐ Widowed Spouse's Name:_____
Number of children/ages?_____
Special Interests/Hobbies:

_____

Do you have Advanced Directives? ☐ Yes ☐ No **Power of Attorney for Medical Care?**_____

Health History Form

Allergies (If any, please list name of agent and reaction such as rash/hives, swelling) ☐ No Known Drug Allergies

_____

_____

Current Prescription Medications ☐ NONE

Name	Dose	How Often	Reason for Use

Non-Prescription/Herbals/OTC/Vitamins ☐ NONE

Name	Dose	How Often	Reason for Use

PREVENTATIVE SCREENING/IMMUNIZATIONS

Exam/Test (*indicate last date performed*)

☐ Cholesterol (Lipid Panel) _____

☐ Glucose (Diabetes) _____

☐ Cardiovascular Disease (EKG) _____

☐ Osteoporosis(Bone Density) _____

☐ Prostate Cancer (PSA/DRE) _____

☐ Breast Cancer (Mammogram) _____

☐ Cervical Cancer (Pap Smear) _____

☐ Colon Cancer (Colonoscopy) _____

☐ Lung Cancer (Chest Xray) _____

☐ Abdominal Aorta (AAA) _____

☐ Carotid Disease (Ultrasound) _____

☐ Echocardiogram _____

☐ Other: _____ _____

Immunizations (*indicate last date administered*)

☐ Pneumovax (Pneumonia) _____

☐ Influenza (Flu) _____

☐ Zostavax (Shingles) _____

☐ Tdap (Tetanus/diphtheria/Pertussis) _____

☐ Td (Tetanus/diphtheria) _____

☐ Hepatitis B _____

☐ Hepatitis A _____

☐ Other:_____ _____

Health History Form

REVIEW OF SYSTEMS Please check any recent or recurring problems:

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain_____lbs
- ☐ Weight Loss_____lbs
- ☐ Exercise Intolerance

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Changes
- ☐ Cataract History

Ears/Nose/Mouth/Throat
- ☐ Ringing in Ears
- ☐ Difficulty Hearing
- ☐ Dizziness/Vertigo
- ☐ Ear Pain
- ☐ Nose/Sinus Issues
- ☐ Snoring
- ☐ Frequent Colds
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Frequent Sore Throats
- ☐ Hoarseness
- ☐ Bleeding Gums
- ☐ Dry Mouth
- ☐ Mouth Breathing
- ☐ Mouth Ulcers

Respiratory
- ☐ Cough
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Pain with Breathing
- ☐ Wheezing
- ☐ Snoring
- ☐ Sleep Apnea

Cardiovascular
- ☐ Arm Pain with Exertion
- ☐ Chest Pain with Exertion
- ☐ Chest Heaviness
- ☐ Irregular Heart Beats
- ☐ Known Heart Murmur
- ☐ Lightheaded on Standing
- ☐ Shortness of Breath w/Exertion
- ☐ Swelling (Edema)

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands
- ☐ Anemia

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black/Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Indigestion ☐ Heartburn
- ☐ Frequent Belching
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Pain with Urination
- ☐ Incomplete Emptying
- ☐ Urinary Loss of Control
- ☐ Urinary Frequency
- ☐ Urinary Urgency
- ☐ Urinary Hesitancy
- ☐ Post-Void Dribbling
- ☐ Erectile Dysfunction

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Fractures
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Use of Assist Device

Neurologic
- ☐ Dizziness/Vertigo
- ☐ Poor Balance
- ☐ Headaches
- ☐ Migraine
- ☐ Memory Loss
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Anxiety
- ☐ Stress
- ☐ Panic Attacks
- ☐ Depression
- ☐ Mania
- ☐ Sleep Problems
- ☐ Alcohol Overuse
- ☐ History of Addiction
- ☐ Suicidal Thoughts
- ☐ Do not feel safe

Integumentary(Skin)
- ☐ Change in Mole
- ☐ Dry Skin
- ☐ Eczema
- ☐ Rash
- ☐ Growth/Lesion
- ☐ Itching
- ☐ Jaundice (yellow skin/eye)

Allergic/Immunologic
- ☐ Sneezing
- ☐ Hives/Rash
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Men Only
- ☐ Pain or Lump in Testicle
- ☐ Penis Burning/Itching/Discharge
- ☐ Prostate Disease/Problems
- ☐ Night-time urination
- ☐ Sexual problems/concerns
- ☐ Low sex drive

Women Only
- ☐ Vaginal Itching/Burning/Discharge
- ☐ Night time urination
- ☐ Breast Tenderness/Discharge
- ☐ Breast Lump
- ☐ Ovarian Cysts

Total Pregnancies _____
Births _____
Miscarriages _____
Abortions _____
Age Menses/Period Started _____

MEN'S PREVENTATIVE WELLNESS PLAN

Name: _____ Date: _____

Preventive Service	Frequency	Last Done
Body Mass Index (BMI)_____ Height _____ Weight _____	**Annually**	
Blood Pressure _____/_____	• **Every 2 yrs, if BP </= 120/80 mmHg** • **Annually, if BP >120-139/80-89 mmHg**	
Vision	• **Every 3 yrs up to age 40;** • **Every 2 yrs aged 40+**	
Abdominal Aortic Aneurysm	• **Once, between the age range of 65-75 and smoked 100+ cigarettes in lifetime**	
Cholesterol Testing	• **Regularly beginning at age 20 with risk factors**	
Diabetes Screening	• **With a sustained BP >/= 135/80 mmHg**	
Colorectal Cancer Screening	• **Annually, Fecal Occult Blood Stool (FOBS);** • **Every 5 yrs, Sigmoidoscopy with FOBS;** • **Every 10 yrs, Colonoscopy**	
Prostate Exam Screening	• **Annual PSA blood work age 40** • **Digital Rectal Exam: Consider annually age 50** • **Age 40-45 if ^Risk factors**	
Sexually Transmitted Diseases (STD's)	• **As necessary for those with risk factors**	
Depression Screening	• **As necessary for those with risk factors**	
Alcohol Misuse Screening	• **As necessary for those with risk factors**	
Immunizations: **Pneumococcal (Pneumonia)** **Influenza (Flu)**	• **Pneumonia: 1-2 doses up to age 64;** • **Pneumonia: 1 dose age 65+** • **Influenza: Annually**	

Your major risk factors:
Family history of: Obesity_____ Diabetes_____ Hypertension_____ Fall Risk_____ Smoking Use_____
Other_____

Recommendations for improvement:
Diet_____ Tobacco Cessation_____ Weight Management_____ Exercise_____Other_____

Referrals

For Staff Use: *[list handouts, referrals, or other follow-up instructions here]*

HIPAA - Notices of Privacy Practices

This notice, effective immediately describes how medical information about you may be used and disclosed and how you can get access to this information, please review carefully. Our office is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for the purpose of payment or health care operations. We have your permission to disclose your health care information to your insurance company for the purpose of appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers' Compensation laws, Public Health Authorities, Emergency situations, Judicial and Administrative proceedings, Law Enforcement, Medical examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals, and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information

I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

_____ _____

Printed Name Date

_____

Signature

ELECTRONIC PRESCRIPTION PHARMACY PREFERENCE

Please choose your preferred retail and/or mail order pharmacy for approved prescriptions to be sent electronically:

LOCAL Pharmacy

Pharmacy name:_____ Phone Number:_____

Address:_____

MAIL ORDER Pharmacy

Pharmacy name:_____ Phone Number:_____

Address:_____

Any controlled substance prescriptions must be hand written and provided at time of office visit

Men's Vitality Center®
The Nation's Leader in Men's Health

Lab Test Result Communication

The foundation of good healthcare is built on timely and thorough communication. We want to give solutions for those who may not be available to accept phone calls during traditional office hours. Additionally, we take our responsibility to protect your privacy seriously. Normal lab results will be reviewed in office during the following visit. If at any time you have questions regarding your test results we are happy to discuss them with you further. Carefully read the options below and choose the option that best fits your needs by initialing it.

Thank you!

_____ **Phone/Voicemail**

Please call me to review my test results. If you do not reach me, you may leave a detailed message on my voicemail with my results.

_____ **Phone Only**

Please call me review my test results. If you do not reach me, please leave a message for a return call. I only want to receive test results by speaking directly to a staff member, and DO NOT want detailed messages left on my voicemail.

_____ **Review at Next Visit**

I would like to review my labs in person at my next office visit.

_____ **Email Only**

Please send my lab results to my email address at _____.
If I have any questions regarding my lab results, I will call the office and speak with a staff member.

Patient Name: _____ **Phone Number:** _____

Patient Signature: _____ **Date:** _____