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

Welcome!

■ About You

Last Name	First Name	Middle Name

Date of Birth			Occupation	Gender
Month	Day	Year		☐ Male ☐ Female

Address		
Street Address	Apartment Number	City

State	ZIP	Social Security Number

Phone Number		
Home Phone Number	Cell Phone Number	Work Phone Number

Email Address	Marital Status	
	☐ Single ☐ Married ☐ Partnered	☐ Divorced ☐ Widowed

■ About Your Insurance

Do you currently have health insurance?	Insurance Company
☐ Yes ☐ No	
Group Number	Policy Number
If you are NOT the primary policy holder, what is his or her name?	If you are NOT the primary policy holder, what is his or her date of birth?

Last Name	First Name	Middle Name

■ **Release of Medical Information**

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

Name of Authorized Person	Relationship to You

■ **About Your Medication History**

Are you ALLERGIC to any Medications?

☐ No ☐ Yes

If yes, to which medications do you have an allergy?

Medication	Type of Reaction

Are you taking any medications right now?

☐ No ☐ Yes

Medication	Dose	Why are you taking this medication?

Last Name	First Name	Middle Name

■ **About Your MEDICAL History**

Have you ever had any of the following illnesses?

Anxiety/panic attacks	☐ No ☐ Yes	Heart problems	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	High blood pressure	☐ No ☐ Yes
Aneurysm	☐ No ☐ Yes	High cholesterol	☐ No ☐ Yes
Bipolar Disorder	☐ No ☐ Yes	Kidney stones	☐ No ☐ Yes
Blood clot	☐ No ☐ Yes	HIV	☐ No ☐ Yes
Blood clotting disorder	☐ No ☐ Yes	Lung disease	☐ No ☐ Yes
Cancer	☐ No ☐ Yes	Multiple sclerosis	☐ No ☐ Yes
Depression	☐ No ☐ Yes	Severe or recurrent muscle or bone pain	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Prostate disease	☐ No ☐ Yes
Eating disorder	☐ No ☐ Yes	Sleep apnea or persistent, loud snoring with gasping	☐ No ☐ Yes
Epilepsy/seizures	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Gout	☐ No ☐ Yes	Testicular disease or injury	☐ No ☐ Yes
Severe or recurrent headaches	☐ No ☐ Yes	Thyroid disease	☐ No ☐ Yes
Heart attack	☐ No ☐ Yes		☐ No ☐ Yes

Do you smoke?	☐ No ☐ Yes ☐ In the past
Do you use smokeless or chewing tobacco?	☐ No ☐ Yes ☐ In the past

Last Name	First Name	Middle Name

■ **About Your SURGICAL History**

Have you ever had surgery?

☐ No ☐ Yes

If yes, what sort of surgery did you have?

Surgery	Year

Last Name	First Name	Middle Name

■ About Your FAMILY Medical History

Have any relatives, who are related to you by blood, experienced any of the following illnesses?

Illness/Condition		Relative(s) affected
Alcohol abuse	☐ No ☐ Yes	
Alzheimer Disease or Dementia	☐ No ☐ Yes	
Blood clot or blood clotting disorder	☐ No ☐ Yes	
Cancer	☐ No ☐ Yes If yes what kind of cancer(s)?	
Depression	☐ No ☐ Yes	
Diabetes	☐ No ☐ Yes	
Heart attack	☐ No ☐ Yes	
Heart disease	☐ No ☐ Yes	
High blood pressure	☐ No ☐ Yes	
Stroke	☐ No ☐ Yes	
Thyroid disease	☐ No ☐ Yes	

Last Name	First Name	Middle Name

■ **How do you wish to hear from us about laboratory results?**

☐ A medical assistant, nurse, or other healthcare provider should call me with my lab results EVERY TIME.

☐ A medical assistant, nurse, or other healthcare provider should call me with my lab results ONLY IF THE RESULTS ARE ABNORMAL.

☐ Please do not call unless it is urgent. I will review the results at my next visit.

■ **Is it okay to leave a message?**

☐ Yes, you may leave a message on my voice mail.

☐ Please do not leave a message on my voice mail unless it is urgent.

To the best of my knowledge, all of the information I have provided is accurate and complete.

_____ _____

Signature Date

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

3395 North Campbell Road
Tucson, Arizona 85719

Phone: 520-399-6574
FAX: 520-838-0295
tucson.mensvitalitycenter.com

Patient Responsibility and Assignment of Benefits

Men's Vitality center is committed to providing you with the best possible healthcare. 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 in the financial policy below.

As a courtesy, we will submit claims for all services rendered to your insurance company. Please note that your individual health insurance policy is a contract between you and your insurance company, and that 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 our insurance policy. 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 a laboratory company, and will be billed to your insurance. If these tests are not covered by your health insurance, you may receive a separate bill from the laboratory company.

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 copayment, coinsurance, 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. Please understand that it is your responsibility to abide by the guidelines set by your individual insurance policy. If your insurance carrier denies the medical claim, you are responsible for timely payment of your account.

Men's Vitality Center may assess fees for late cancellation of appointments, late arrivals for appointments, and no-shows for scheduled appointments.

I have read the financial policy for Men's Vitality Center, and I understand that I am responsible for all charges on my account. I tis my financial responsibility to supply payment for any charges not covered by my insurance plan, including—but not limited to—coinsurance, copayments, and deductibles. I understand that copayments are due at the time of service.

_____ _____

Signature Date