

## Male Patient Questionnaire & History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
(Last) (First) (Middle)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Address City State Zip

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

### Social:

- ( ) I am sexually active.
- ( ) I want to be sexually active.
- ( ) I have completed my family.
- ( ) I have used steroids in the past for athletic purposes.

### 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

Any known drug allergies: \_\_\_\_\_

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

If yes please explain: \_\_\_\_\_

Medications Currently Taking: \_\_\_\_\_

Current Hormone Replacement Therapy: \_\_\_\_\_

Past Hormone Replacement Therapy: \_\_\_\_\_

Nutritional/Vitamin Supplements: \_\_\_\_\_

Surgeries, list all and when: \_\_\_\_\_

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.

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone Pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Print Name

Signature

Today's Date



## BHRT CHECKLIST FOR MEN

Name: \_\_\_\_\_

Date: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Symptom (please check mark)**

**Never      Mild      Moderate      Severe**

Decline in general well being				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/lacking vitality				
Declining Mental Ability/Focus/Concentration				
Feeling you have passed your peak				
Feeling burned out/hit rock bottom				
Decreased muscle strength				
Weight Gain/Belly Fat/Inability to Lose Weight				
Breast Development				
Shrinking Testicles				
Rapid Hair Loss				
Decrease in beard growth				
New Migraine Headaches				
Decreased desire/libido				
Decreased morning erections				
Decreased ability to perform sexually				
Infrequent or Absent Ejaculations				
No Results from E.D. Medications				

**Family History**

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		



Ernesto R. Padron, M.D.  
Interventional Pain Management Specialists  
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## NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information use or disclosed by us in any form, whether electronically, paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new right to understand and control how much health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We respect patient confidentiality and only release medical information about you in accordance with the Nebraska federal law. This notice describes our policies related to the use of the records or your care generated by ERNESTO R. PADRON, M.D., LLC.

We may use and disclose your medical records only for the following reasons:

1. **Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers. For example: A physical exam
2. **Payment:** obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example: Sending a bill for your visit to insurance company for payment.
3. **Health Care Operations:** the business aspects of running a practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. For example: Internal quality assessment.

### Information Disclosed Without your consent

Under Nebraska federal law, information about you may be disclosed without your consent for the following reasons:

1. **Emergency:** sufficient information may be shared to address the immediate emergency are facing.
2. **Follow-Up Appointments:** we will be contacting you to remind you of future appointments or Information about your treatment alternatives or other health -related benefits and services that may be interest to you.

3. **Required by Law:** includes situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable disease or suspected abuse and neglect such as child abuse, elder abuse or institutional abuse.
4. **Coroners, Funeral Director, and Organ Donation:** medical information is disclosed to coroner or medical examiner and funeral directors for the purpose of carrying out their duties. When organs are donated sufficient information will be provided to the program as necessary to facilitate the organ or tissue donation.
5. **Governmental Requirements:** information to health oversight for activities authorization by law: such as audits, investigation, or licensure, there may also be need to share information with the Food and Drug Administration related to adverse events or product defects as well with the Department of Health and Human Services to determine our compliance with the federal laws related to health care upon request.
6. **Criminal activity or Danger to others:** if a crime is committed on our premises or against our personnel we may share the information with the law enforcement to apprehend the criminal. We have the right to involve law enforcement when we believe an immediate danger may occur to someone.

Any other use, or disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to extent that we have already taken actions relying on your authorization.

You have the following rights with respect to protect health information:

1. The right request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other identified by you. We are not required to agree to a request restriction. If we agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable request to receive confidential communication of protected health information from us by alternative means or at alternative locations.
3. The right to inspect and copy your protected health information at the cost of a reasonable fee copying and mailing your records.
4. The right to amend your protected information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, the Department of Health & Human Services, or Office of civil rights, about violations of the provision of this notice or the policies and procedures of our office.

- If you have any questions or need more information, please contact our office

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

PAIN MANAGEMENT SPECIALISTS  
ERNESTO PADRON, M.D., L.L.C.



SOUTH OMAHA SURGICAL CENTER  
3201 S. 24TH ST.  
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P: 844-365-6766/F: 847 696 7040

### ASSIGNMENT OF BENEFITS

Patient Name: \_\_\_\_\_

SSN: \_\_\_\_\_

In consideration of your undertaking to render care, I agree to the following:  
En consideración por darme tratamiento médico yo acepto lo siguiente:

- **Release of Information:** I authorize the release of any information I deem appropriate concerning my medical condition to any insurance company, attorney, adjuster, or any other person necessary for me to process any claim for reimbursement of charges insured by me at Ernesto Padron M.D, LLC.

Ud. está autorizado a proveer cualquier información Ud. considere propia y en referencia a mi condición médica a cualquier compañía de seguros, abogados, representate u otra persona necesaria para el proceso de cargos debido a mi tratamiento médico en Ernesto Padron M.D, LLC.

- **Right to Receive Payment:** I authorize and assign you, the medical provider and treating facility, Ernesto Padron M.D, LLC, the right to receive direct payment from my attorney, insurance company, or any other party who may become obligated to pay me any sums. I further authorize endorsement of my name to any draft which you are legally entitled.

Yo autorizo y asigno, al médico en Ernesto Padron M.D, LLC, el derecho de recibir directamente pago de mi abogado, compañía de seguros, y otro médico, quien esta obligado a pagarme cierta cantidad. Yo además autorizo al centro que firme mi nombre a cualquier forma de pago que contenga mi nombre y por lo cual le pertenece legal mente.

- **Assignment of Right to Sue:** In the event any insurance company, attorney, or other person obligated to contractual agreement refuses to make a payment upon your demand for your services; I hereby assign and transfer Ernesto Padron M.D, LLC, the cause of action that exists in my favor against such parties and authorize you to prosecute said action either in my name or your name for you to resolve said claims as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account. I also understand that a 33% collection fee, in addition to attorney fees will be collected upon demand.

En el caso que la compañía de seguros, o abogados, o otra persona encargada debido a un contrato no pagar a Ernesto Padron M.D, LLC, bajo la demanda, yo autorizo que se haga acción legal para procesar mi cuenta. Yo entiendo que seguiré responsable por todos los cargos por los servicios médicos. Yo también entiendo que en 33% será agregado por costos de colección y además de los gastos de abogados.

- **Attorney Direction:** I hereby direct my attorney not to interfere with my claim on any lien upon, any medical payment benefits to which I may be entitled for my health insurance, medical, workmen's compensation, or other payment sources. If there are any said medical payment checks which include my attorney's name, I

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direct my attorney to sign his/her name to these checks for the benefit of the medical provider and Ernesto Padron M.D, LLC.

Yo indicare a mi abogado que no Interfiera con "Ifen" presentada y cualquier benefició por el cual a mi pertenece ya sea de mi seguro de salud, compensación de trabajo o otra forma. Y si alguno de esos pagos incluye el nombre de mi abogado, Yo indicare a mi abogado para que endorse su nombre y pague al médico y a Ernesto Padron M.D, LLC, que me proveyó de los servicios.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

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### PATIENT CONSENT FORM

#### CONSENT TO THE USE AND DISCLOSURE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I understand, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

I, \_\_\_\_\_ consent to the use of disclosure of my medical information by Ernesto Padron M.D, LLC, for the purpose of diagnosing or providing treatment to me, obtain payment for my treatment, or to conduct healthcare operation of the practice. I understand treatment by the practice may be denied if I do not sign this consent.

I have been informed by Ernesto Padron M.D, LLC, of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand Ernesto Padron M.D, LLC has the right to change the Notice of Privacy Practices from time to time and I may contact Ernesto Padron M.D, LLC, at any time at above address to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing Ernesto Padron M.D, LLC, restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Ernesto Padron M.D, LLC, is not required to agree to my requested restrictions, but if agreed upon, Ernesto Padron M.D, LLC, must abide by such restrictions.

I understand I may revoke this consent in writing at any time, except where Ernesto Padron M.D, LLC, has already made disclosure in reliance on prior consent.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness