



## Female New Patient Package

The contents of this package are your first step to restore your vitality.

Please take time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in BioTE Medical®. In order to determine if you are a candidate for bio-identical testosterone pellets, we need laboratory and your history forms. We will evaluate your information prior to your consultation to determine if BioTE Medical® 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 lab drawn at any Arthrotec/or LabCorp Lab. We offer those both here at the clinic. If you are not insured or have a high deductible, call our office for self-pay blood draws. 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. **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 (CPT 82670)
- FSH (CPT 83001)
- Testosterone Total (CPT 84403)
- Testosterone Free (84402)
- TSH (CPT 84443)
- T4, Total (CPT 84436)
- T3, Free (CPT 84481)
- T.P.O. Thyroid Peroxidase (CPT 86376)
- CBC (CPT 85027)
- Complete Metabolic Panel (CPT 80053)
- Vitamin D, 25-Hydroxy (CPT 82306)
- Vitamin B12 (CPT 82607)
- Lipid Panel (**Must be a fasting blood draw to be accurate**) (CPT 83701, 83704, 84478-59)

### Female Post Insertion Labs Needed at 4, 6 or 8 Weeks based on your practitioner's choice:

- FSH (CPT 83001)
- Testosterone Total (CPT 84403)
- CBC (CPT 85027)
- Lipid Panel (Optional) (**Must be a fasting blood draw to be accurate**) (CPT 83701, 83704, 84478-59)
- TSH, T4 Total, T3 Free, TPO (**Needed only if you've been prescribed thyroid medication**) (CPT 84443, CPT 84436, CPT 84480, CPT \_\_\_\_\_ )



## Female 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.
- ( ) My sex has suffered.
- ( ) I haven't been able to have an orgasm.

### Habits:

- ( ) I smoke cigarettes or cigars \_\_\_\_\_ per 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: \_\_\_\_\_

Last menstrual period (estimate year if unknown): \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

### Preventative Medical Care:

- ( ) Medical/GYN Exam in the last year.
- ( ) Mammogram in the last 12 months.
- ( ) Bone Density in the last 12 months.
- ( ) Pelvic ultrasound in the last 12 months.

### High Risk Past Medical/Surgical History:

- ( ) Breast Cancer.
- ( ) Uterine Cancer.
- ( ) Ovarian Cancer.
- ( ) Hysterectomy with removal of ovaries.
- ( ) Hysterectomy only.
- ( ) Oophorectomy Removal of Ovaries.

### Birth Control Method:

- ( ) Menopause.
- ( ) Hysterectomy.
- ( ) Tubal Ligation.
- ( ) Birth Control Pills.
- ( ) Vasectomy.
- ( ) Other: \_\_\_\_\_

### 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 or Avodart.
- ( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
- ( ) Diabetes.
- ( ) Thyroid disease.
- ( ) Arthritis.
- ( ) Depression/anxiety.
- ( ) Psychiatric Disorder.
- ( ) Cancer (type): \_\_\_\_\_

Year: \_\_\_\_\_





## Hormone Replacement Fee Acknowledgment

Although more insurance companies are reimbursing patients for the BioTE® Medical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure.

We will give you paperwork to send to your insurance company to file for reimbursement upon request.

<b>New Patient Consult Fee</b>	<b>\$125</b>
<b>Female Hormone Pellet Insertion Fee</b>	<b>\$300</b>
<b>Male Hormone Pellet Insertion Fee</b>	<b>\$600</b>
<b>Male Pellet Insertion Fee (<math>\geq 2000\text{mg}</math>)</b>	<b>\$700</b>

**We accept the following forms of payment:**

**Master Card, Visa, Discover, Personal Checks and Cash.**

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Print Name

Signature

Today's Date