Well Balance Center

1110 East Austin St.
Paris, Texas 75460
Phone: (903) 785-6156
Fax: (903) 785-6740

Male Patient Information

Name: ____ ________________
First Middle Last Name Used

Date of Birth: ____________________ Social Security #: ____________________

Race: __________ Ethnicity: ______________ Language: ________________

Address: ____

City: ______________________________ State: ______ Zip code: __________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____

E-mail address? ____

Employed By: ____

Marital Status: ☐ Married ☐Divorced ☐Single ☐Widow ☐ Living With Sig. ☐ Other

Spouse's Name: ____
First Last

Emergency Contact & Phone Number: ______________________________

Do you have a Family Doctor? ______________________________

Phone number(s): ______________________________

Thank you for selecting Dr. Zimmerman for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience we accept Visa, MasterCard, cash and checks.

I AGREE THAT SHOULD THIS ACCOUNT BE REFERRED TO AN AGENCY OR ATTORNEY FOR COLLECTION, I WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS, ATTORNEY'S FEES, AND COURT COSTS.

Signature: ______________________________ Date: ______________

SEXUAL HISTORY

1. Age of first sexual contact ______________________
2. Are you sexually active? ☐ YES ☐ NO
3. Do you have history of sexually transmitted diseases? ☐ YES ☐ NO
   If yes, please list: ______________________
4. Have you had the mumps? ☐ YES ☐ NO
   Year: ______________________
5. Are you HIV positive? ☐ YES ☐ NO
   Had Treatment? ☐ YES ☐ NO
6. Have you ever been tested for AIDS? ☐ YES ☐ NO
   Results: ______________________
7. Have you fathered any children? ☐ YES ☐ NO
   If yes, how many? __________
8. Sexual Orientation ☐ Heterosexual ☐ Homosexual ☐ Bisexual
9. Have you had testicular cancer? ☐ YES ☐ NO
   Year: ______________________
10. Do you have or had prostate problems? ☐ YES ☐ NO
11. Have you had blood in your urine? ☐ YES ☐ NO
    Last Date: ______________________
12. Do you have erectile dysfunction? ☐ YES ☐ NO
    If yes, please describe: ______________________
13. Do you initiate intercourse? ☐ YES ☐ NO
14. Is intercourse satisfying? ☐ YES ☐ NO
15. Do you achieve orgasm? ☐ YES ☐ NO
16. How often do you have intercourse? ______________________
17. Is your sex drive the same as it was five years ago? ☐ YES ☐ NO
18. List any other sexual dysfunctions: ______________________

____
19. Have you experienced weight gain in the last one-two years? ☐ YES ☐ NO
20. Have you lost greater than 10 pounds in less than a month? ☐ YES ☐ NO
21. Have you had your testosterone level taken? ☐ YES ☐ NO
22. List current medications:

____

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ diabetes
- ☐ hypertension
- ☐ heart murmur
- ☐ mitral valve prolapse
- ☐ urinary tract infection
- ☐ hepatitis/liver disease
- ☐ thyroid problems
- ☐ blood transfusions
- ☐ lupus/arthritis
- ☐ heart disease
- ☐ rheumatic fever
- ☐ kidney disease
- ☐ psychiatric problems
- ☐ varicosities/phlebitis
- ☐ major accidents
- ☐ asthma/lung disease

1. Do you have any Drug Allergies? ☐ YES ☐NO
   If yes, please list: ______________________________

2. Please list any surgeries: ______________________________

3. Please list any other hospitalizations (include year & reason): ______________________________

4. Have you had any anesthesia complications? ☐ YES ☐NO
   If yes, please list: ______________________________
5. Have you ever been anemic? ☐ YES ☐NO

SOCIAL HISTORY

1. Do you smoke cigarettes/smokeless tobacco/dip/chew? ☐ YES ☐NO
   If yes, how many per day? ______________ Number of years? ______________
2. Do you use street drugs? ☐ YES ☐NO
   If yes what drugs? ______________________________
3. Do you drink alcohol? ☐ YES ☐NO
   If yes, how much per day?

FAMILY HISTORY

1. Do you have a family history of breast cancer? ☐ YES ☐NO
   If yes, whom? ______________________________
2. Do you have a family history of colon cancer? ☐ YES ☐NO
   If yes, whom? ______________________________
3. Do you have a family history of osteoporosis? ☐ YES ☐NO
   If yes, whom? ______________________________
4. Do you have a family history of diabetes? ☐ YES ☐ NO
   If yes, whom? ______________________________
5. Do you have a family history of hypertension? ☐ YES ☐NO
   If yes, whom? ______________________________
6. Do you have a family history of heart disease? ☐ YES ☐NO
   If yes, whom? ______________________________
7. Do you have a family history of kidney disease? ☐ YES ☐NO
   If yes, whom? ______________________________

Patient Authorization to Disclose Protected Health Information to Family/Provider of Care

I, ______________________________, understand that Robert O. Zimmerman, M.D. and the office staff are authorized to disclose my protected health information by telephone or in person to the people that I have listed below.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone ______________________________

☐ OK to leave message with detailed information ☐ Leave message with callback number only

☐ Work Telephone ______________________________

☐ OK to leave message with detailed information ☐ Leave message with callback number only

☐ Written Communication

☐ Ok to mail to my home ☐ Ok to mail my home/office

☐ Ok to fax to this number ______________________________

☐ Other ______________________________

____

Name(s) of person(s) authorized by this form to disclose my protected health information:

Name(s) & Relationship(s)	Allowed Information
______________________________	☐ Appointment ☐ Testing ☐ Medical ☐ Billing
______________________________	☐ Appointment ☐ Testing ☐ Medical ☐ Billing
______________________________	☐ Appointment ☐ Testing ☐ Medical ☐ Billing

I understand that I have the right to revoke anyone listed on the authorization and fill out the form before the revocation can be completed. This request must be done in writing.

All revocations must be sent to Robert O. Zimmerman, M.D. to the attention of the Privacy Officer and are not effective until received by the Privacy Officer.

I fully understand and accept the terms of this authorization.

Patient Signature ______________________________ *Date* ______________

FOR OFFICE USE ONLY

Authorization added to the patient's record on ______________________

Authorization verified by ______________ on ______________________

Robert O. Zimmerman

NO SHOW/MISSED APPOINTMENT POLICY

Effective September 1st, 2011

To ensure each patient is given the proper amount of time for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time.

If it is necessary to reschedule the appointment, please call us immediately. An appointment reminder call to you is made/attempted 2 days prior to your scheduled appointment.

A minimum of **24 hours cancellation notice** is required for appointments. If less than a 24 hour cancellation is given, the appointment becomes a "Missed" appointment. If you do not cancel in advance, and do not present to the office for your appointment, this will be considered a "No-Show" appointment.

After the "No-Show/Missed" appointment, The Well Balance Center will attempt to call and reschedule your appointment and a **$25.00 fee will be charged to your account.**

We understand that circumstance arise that do not allow you to keep your appointment, but please remember to be courteous to us and our other patients by calling at least **24 hours** prior to your appointment time to cancel if you cannot make it. You may also leave a voicemail or email to cancel your appointment.

Signature:__________________________ **Date:**__________