TRILLIUM
MEDICAL

Men's Intake Form

Health history & patient information

H & P FOR MEN

Patient name: _____
First Middle Last

Birthday: _____ Reason for visit: _____

HPI / Current problems: _____

_____

_____

_____

MEDICAL HISTORY

Past medical history (circle all that apply)

High blood pressure / Weight gain / Diabetes
Urinary tract infection / Anxiety / Depression
Thyroid disease / Erectile dysfunction

Past surgeries: _____

_____

VITALS

BP: _____ Pulse: _____ RR: _____

Wt: _____ Ht: _____

MEDICATIONS & HISTORY

Medications / supplements: _____

Allergies: _____

Family history of cancer: _____

REFERRAL & CONTACT DETAILS

Referred by: _____

Physician: _____ Other: _____

DEMOGRAPHICS

Patient name: _____

Home phone: _____

Cell phone: _____

Occupation: _____

Email address: _____

Home address: _____

City: _____ State: _____ ZIP: _____

Date of birth: _____ SSN: _____

EMERGENCY CONTACT

Name: _____

Date of birth: _____

Relationship: _____

Phone: _____

Email: _____

Address: _____

MEDICAL INSURANCE INFORMATION

Do you have medical insurance? ☐ Yes ☐ No

Responsible party: _____

Relationship: _____

Insurance provider: _____

Policy holder: _____

Subscriber ID: _____

Group #: _____

Medi-Cal / Presumptive Eligibility #: _____

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Acknowledgments & consents

HIPAA NOTICE OF PRIVACY PRACTICES

Acknowledgment Letter
I hereby acknowledge that I have had access to a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I have had the right to review this medical practice's Notice of Privacy Practices prior to signing this acknowledgment letter. Additionally, I acknowledge that a copy of the current Notice of Privacy Practices will be available at the front desk upon request.

Signature: _____ Date: _____

AUTHORIZATION FOR MEDICAL TREATMENT

I, _____ (patient name), hereby authorize Dr. Troy Williams and associates and assistants as designated by Dr. Troy Williams to perform evaluation and treatment of my medical condition. I further require and authorize Dr. Troy Williams, associates, and assistants to perform such additional procedures as they may deem necessary on an emergent basis.

I understand that elective minor surgical procedures may be consented to verbally or by contract. I recognize that the practice of medicine is not an exact science, and Dr. Troy Williams does not guarantee results of treatment.

Signature: _____ Date: _____

CONSENT FOR TELEMEDICINE CARE

I understand that telemedicine visits are a privilege and a covered benefit of my health plan. The visits are designed to accomplish just as much as an in-person visit. While in-person visits are available weekly, a televisit may allow me to avoid taking a day off work, driving to and from the office during rush hour, or paying for the cost of child care to attend an in-person office visit.

I understand that telemedicine visits cost the same amount as an in-person visit and that my copay and yearly deductibles still apply. I agree to be billed my emailed statements for any costs that my insurance considers a patient responsibility after my insurance processes the claims.

I understand that the timeframe for the visit may be plus or minus 10-15 minutes. Wait times may be even longer on a busy day (just like an in-office visit). The visit itself may be 10 minutes to 45 minutes long depending on what problems are being addressed. Telehealth visits are appropriate to address simple needs like medication changes and refills but also problems like UTI or STD concerns without going to an Urgent Care/ER.

Signature: _____ Date: _____

FINANCIAL POLICY

Thank you for choosing our office. Attached below is our updated Financial Policy as of 8/18/2026.

I understand and agree to the above stated Financial Policy.

Signature: _____

Date: _____

AMBIENT DICTATION / AI SCRIBE CONSENT

I understand that during my visits, an AI-powered ambient dictation tool may be used to help my provider take notes. This technology listens to the conversation in the exam room and generates clinical documentation to help support my care.
I understand that all information is handled in accordance with HIPAA and our privacy policies. I consent to the use of this technology.

Signature: _____

Date: _____

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Clinical history, notes & certification

PHYSICAL EXAM

ASSESSMENT / PLAN

ADDITIONAL NOTES / QUESTIONS

INSURANCE ACKNOWLEDGMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company, as per the financial policy agreement.

Signature: _____ Print name: _____ Date: _____

PATIENT CERTIFICATION

I certify that the information on this form is true and complete to the best of my knowledge. I understand that providing false information may be grounds for dismissal from the practice.

Signature: _____ Date: _____