FP#_____

Patients Pharmacy Information

Please Print

Patient's Name (First & Last) Date of Birth

/ /

Address Phone Number

- -

Pharmacy Name & Location

Phone: Fax:

Pharmacy Phone Number & Fax Number

FERTILITY PARTNERSHIP

Patient Registration Female

A.1

Patient Information

Name (Last, First, Middle Initial)			Date of Birth	Social Security Number
Address	City	State		Zip Code
Email Address				Cell Phone
Employer	Occupation			Alt. Phone Number
Employment Address	City	State	Zip	Work Phone
Referring Physician	City	State		
How did you hear about our practice?				
Spouse's Name			Date of Birth	Social Security Number
Address ☐ **(Check if same as above)**	City	State		Zip Code
Employer	Occupation			Cell Phone
Employment Address	City	State	Zip	Alt. Phone Number

Insurance Information

Provider Name		Effective Date	Relationship _____Self _____Spouse
Insurance Co. Address	City	State	
Member ID Number	Group Number	Expiration Date	
Secondary Insurance Co.Name			Relationship _____Self _____Spouse
Secondary Insurance Co. Address	City	State	
Secondary Insurance Member ID Number	Group Number	Effective Date	

FERTILITY PARTNERSHIP

Patient Registration (Cont.)

A.2

Patient's Responsibilities:

I understand that as the patient, parent, or guardian, I am legally responsible for payment of all charges relating to my care. Patient and/or guarantor(s) agree to pay responsible attorney's fees and cost of **Patient's Certification, Authorization to Release Information and Payment Request**: I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to the insurance company or its representatives, any information needed for this or other insurance claim. In consideration of services rendered, I transfer and assign to the Fertility Partnership, any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent.

Patient Signature

Date / /

FERTILITY PARTNERSHIP

Authorization of Medical Information

B.1

Please read the following questions carefully and sign at the bottom

1. May we leave a voicemail about your medical information on your cellular device? .....□ Yes □ No
2. May we contact you via text? .....□ Yes □ No
3. May we leave a message at your place of employment to contact this office? .....□ Yes □ No
4. May we contact you by email? .....□ Yes □ No

   Email address: _____
5. May we discuss your medical condition/results with members of your family or spouse/partner?.....
   ..... □ Yes □ No

If yes to question 5, please list below the name of that person(s) and their relationship to you:
(For Example, if you are ok with a spouse calling for your results, list them below)

Name of Person (please print)	**Relationship to Patient** (please print)
Example: Jane Doe	*Wife*

Please list any information from your chart at Fertility Partnership and their staff to release information **NOT** wish to have disclosed:

_____

_____

_____

I understand that I will need to sign a separate records release form to release any/all medical records to myself or any other treating physician.

I have read and received the Fertility Partnership's Notice of Privacy Practices.

_____ / /

Patient or Legal Guardian's Signature Date

This release may be rescinded at any time in writing. The Fertility Partnership cannot guarantee your request will be honored to the fullest. In the event of an emergency, Fertility Partnership will disclose information that is related to your emergency condition.

FERTILITY PARTNERSHIP

Consent to Process Insurance/Self Pay

C.1

Consent to Process Insurance

I authorize Fertility Partnership to submit all claims for services received today or for any on-going cycle/procedure received at Fertility Partnership to my insurance provider.

Please select one of the following:

☐ I have insurance

☐ I am a self-pay patient and hold all responsibility for all my services received.

_____

Print Name

_____

Signature

____/____/_____

Date

5401 Veterans Memorial Parkway #201
St. Peters, MO 63376

No Show Policy

I hereby understand and agree that I will be charged a $50.00 fee for a New Patient Consult if I do not show for my appointment.

I understand and agree that I will be charged a $25.00 fee for any upcoming future appointments at Fertility Partnership that is a no show or that I canceled less than a 24 hour notice and will be held responsible for paying the bill.

_____

Print Name

_____

Sign Name

_____/_____/_____

Date

FERTILITY PARTNERSHIP

Infertility History – Contact Information

1.0

*(**IMPORTANT:** Please complete all forms and bring them with you to your scheduled visit.)*

Patient

First Name _____ Middle Initial _____ Last Name _____ Age _____

Date of Birth (mm/dd/yy) _____ Occupation _____

Address _____ City _____ State _____ Zip _____ Country _____

Indicate which number to call or leave messages:

Cell phone _____ Work phone _____ Home phone _____

Are you married? ☐ Yes ☐ No ☐ Divorced

Spouse/Partner

First Name _____ Middle Initial _____ Last Name _____ Age _____

Date of Birth (mm/dd/yy) _____ Occupation _____

Address _____ City _____ State _____ Zip _____ Country _____

Indicate which number to call or leave messages:

Cell phone _____ Work phone _____ Home phone _____

Are you married? ☐ Yes ☐ No ☐ Divorced

Who referred you?

☐ Physician ☐ Former Patient ☐ Friend ☐ Web site ☐ Insurance Co

Name of who referred you _____

Who is your OB/GYN or Urologist?

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Who is your Primary Care Physician?

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

FERTILITY PARTNERSHIP

Infertility History – Female History

2.0

Female Medical History and Information

Reason for visit? ☐Infertility evaluation ☐Sperm Insemination ☐Well Woman Exam

What are your expectations for your visit? _____

_____

What questions do you want answered at this visit? _____

_____

Do you have any personal, ethical or religious objections to any of our tests or treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? ☐No ☐Yes _____

How many months have you been having intercourse without using any form of birth control? _____

Pregnancy Summary

- Total number of ALL pregnancies _____ • Number of miscarriages (less than 20 weeks)_____
- Number of ectopic/tubal pregnancies _____ • Number of elective terminations (abortions)_____
- Number of full term deliveries _____ of these, how many were live births? _____ How many were stillborn? _____
- Number of premature (less than 37 weeks) _____ of these, how many were live births? _____ How many were stillborn? _____
- Any pregnancies with birth defects? ☐No ☐Yes _____

Date pregnancy ended or delivered	Months to conception	Treatments to conceive	Delivery type D&C/Complications	Current partner?
1.				☐ Yes ☐ No
2.				☐ Yes ☐ No
3.				☐ Yes ☐ No
4.				☐ Yes ☐ No
5.				☐ Yes ☐ No
6.				☐ Yes ☐ No

Menstrual History

- Menstrual cycle pattern (check all that apply) ☐Regular ☐Irregular ☐Spotting before ☐No periods ☐Heavy ☐Light ☐Bleeding between
- Number of days between the start of one period to the start of the next period: _____days
- How many days of bleeding do you have? _____days
- Dates of the 1st day of your last 2 menstrual periods: _____ • Age when you had your first period: _____ years old
- Age when you first noticed breast development? _____ Years old • Pubic hair? _____ Years old • Underarm hair? _____years old
- How many periods do you have per year? _____
- Do you need any medication to bring on a period? ☐No ☐Yes (what type) _____
- If you do NOT have periods, at what age did you stop having them? _____years old
- Do you have severe cramping or pelvic pain with your periods? ___Yes ___No If yes, explain_____

FERTILITY PARTNERSHIP

Infertility History – Female History (cont.)

2.1

Contraceptive History

☐None ☐Condoms (dates of use) _____ ☐Diaphragm (dates of use) _____ ☐IUD (dates of use) _____

☐Birth control pills (dates of use) _____ Complications? _____ ☐Never used birth control pills

☐Injectable contraception (Depo-Provera,® Lunelle,™ etc.) _____ Complications? _____

☐Skin patch (dates of use) _____ Complications? _____ ☐Foam or Jelly? _____

☐Tubal sterilization procedure (Tubes tied) (mm/yy) _____ ☐ Tubes untied (mm/yy) _____

• Did your mother take DES when she was pregnant with you? ☐Yes ☐No ☐ Don't know

Sexual History

*How many times do you have intercourse per week? _____ ☐None ☐Not applicable

*Have you used over-the-counter ovulation kits to time intercourse? ☐Yes ☐No

*Do you have pain with intercourse? ☐Yes ☐No

* Do you use lubricants (K-Y Jelly®, etc.) during intercourse? ☐Yes ☐No If yes, what type_____

*Have you had any of the following sexually transmitted diseases or pelvic infections? ☐Yes ☐No (Check all that apply)

☐ Chlamydia (date_____) ☐ Gonorrhea (date_____) ☐ Herpes (date_____) ☐ Genital warts/HPV (date_____)

☐ Syphilis (date_____) ☐ HIV/AIDS (date_____) ☐ Hepatitis (date_____) ☐ other (date_____)

Pap Smear History

- When was your last pap smear? (mm/yy) _____ ☐ Normal ☐ Abnormal
- When was your last abnormal pap smear? (mm/yy) _____ ☐ Not applicable
- Have you undergone any procedures as a result of an abnormal pap smear? ☐ No ☐ Yes (check all that apply)

☐ Colposcopy ☐ Cryosurgery (freezing) ☐ Laser treatment ☐ Conization ☐ LEEP procedure

Breast Screening History

- Have you ever had a mammogram? ☐ No ☐ Yes (Date_____) Result: ☐ Normal ☐ Abnormal (Explain) _____

_____

- Do you perform breast self-exams? ☐ No ☐ Yes

_____

FERTILITY PARTNERSHIP

Infertility History – Female History (cont.)

2.2

Medical History

Are you allergic to any medications? ☐No ☐Yes (Please list and describe medications) _____

_____

Are you allergic to any foods (peanuts, eggs, etc.)? ☐No ☐Yes (Please list and describe reactions) _____

_____

List any medications you are currently taking, including over-the-counter medicines. _____

_____

Do you take any herbal medicines/vitamins or health food store supplements? ☐No ☐Yes (Please list) _____

_____

Do you have any medical problem(s)? ☐ No ☐ Yes (Please list type, dates and treatments)

Type	Dates	Treatments
1)		
2)		
3)		
4)		
5)		
6)		

Did you have either of these childhood illnesses? ☐ Chickenpox (Varicella) ☐ German Measles (Rubella) ☐Don't know

☐Other childhood diseases _____

Vaccinations

• Chickenpox (Varicella)	☐ No	☐ Yes (dates) _____	☐Don't know
• MMR – Measles, Mumps, and Rubella (German Measles)	☐ No	☐ Yes (dates) _____	☐Don't know
• BCG (Tuberculosis)	☐ No	☐ Yes (dates) _____	☐Don't know
• Hepatitis B	☐ No	☐ Yes (dates) _____	☐Don't know
• Polio	☐ No	☐ Yes (dates) _____	☐Don't know
• Hepatitis A	☐ No	☐ Yes (dates) _____	☐Don't know
• Tetanus	☐ No	☐ Yes (dates) _____	☐Don't know
• Influenza	☐ No	☐ Yes (dates) _____	☐Don't know

FERTILITY PARTNERSHIP

Infertility History – Female History (cont.)

2.3

Social History

- How many caffeinated beverages (coffee, soda, tea) do you drink per day? _____ ☐None
- Do you smoke cigarettes? ☐No ☐Yes (#/day _____) How many years? _____ ☐ Quit (when?) _____
- Do you use any form of Vapor or smokeless tobacco? If so, what do you use? _____
- Do you drink alcohol? ☐ No ☐ Yes ☐ Beer (#/week _____) ☐Wine (#/week _____) ☐Liquor (#/week _____)
- Do you use marijuana, cocaine or any other similar drug? ☐No ☐Yes (describe) _____

  _____
- Do you exercise? ☐No ☐Yes (describe) _____
- Are you aware of any radiation exposures other than X-rays? ☐ No ☐ Yes (describe) _____

Surgical History

- Have you had any surgeries? ☐No ☐Yes (Please list all surgeries in chronological order)
- Did you have any anesthesia problems? ☐No ☐Yes (describe) _____

Type and Reason	Year
1)	
2)	
3)	
4)	
5)	
6)	

What is your Ancestry?			Would you like to be screened for . . .
African-American	Cajun/French Canadian	Northern European	Cystic Fibrosis ☐ Yes ☐ No
American Indian/Native American	Caucasian	Southern European	Sickle Cell Anemia ☐ Yes ☐ No
Ashkenazi Jewish	Eastern European	Other (specify)	Tay-Sachs Disease ☐ Yes ☐No
Asian-American	Hispanic/Caribbean		Thalassemia ☐ Yes ☐ No

FERTILITY PARTNERSHIP

Infertility History – Female History (cont.)

2.4

General	Musculoskeletal	Breasts
□ None	□None	□None
□ Recent weight gain or loss	□Unusual muscle weakness	□Discharge
□ Anorexia/Bulimia	□Decreased energy/stamina	□Lumps
□ Lack of energy	□Rheumatoid arthritis	□Pain
□Fever/Chills	□Lupus Erythematosus	□Cancer
□Other	□Myasthenia Gravis	□Abnormal Mammogram
Endocrine/Hormonal	□Other	□Reduction
□None	**Mental Health Problems**	□Augmentation/Implants
□Diabetes	□None	□Other
□ Hair Loss	□Depression	**Genitourinary**
□Thyroid	□Anxiety	□None
□Thyroid Gland Problems	□Schizophrenia	□Bladder Infections
□Rapid Weight gain or loss	□Other	□Kidney Infections
□Excessive hunger/thirst	**Head, Eyes, Nose, Throat**	□Vaginal Infections
□Temperature Intolerance	□None	□Frequent Urination
□Other	□Dizziness	□Leaking Urine
Gastrointestinal	□Headaches	□Blood in Urine
□None	□Blurred Vision	□Herpes
□Nausea/Vomiting	□Hearing Loss/Deafness	□Other
□Hepatitis	□Loss of Sense of Smell	**Hematologic**
□Ulcers	□Chronic Nasal Congestion	□None
□Diarrhea	□Ringing in Ears	□Blood Clotting Disorder
□Constipation	□Other	□Sickle Cell Anemia
□Irritable Bowel Syndrome	**Skin/Extremities**	□Thrombophlebitis
□Blood in your Stool	□None	□Easy Bruising
□Change in Bowel Habits	□Unexplained rash/inflammation	□Swollen Glands
□Colitis (Ulcerative or Crohn's)	□Acne	□Blood Transfusions
□Other	□Skin Cancer	(Dates/Reasons):
Respiratory	□Burn Injury	
□None	□Moles changing in Appearance	□Other
□Shortness of Breath	□Excess Hair Growth	
□Asthma	□Other	
□Bronchitis		
□Pneumonia		
□Tuberculosis		
□Bloody Cough		

Cardiovascular	Neurological Problems	
□None	□None	
□Chest Pain	□Weakness	
□Heart Attack	□Seizers/Epilepsy	
□Stroke	□Headaches	
□Murmurs	□Migraine Headaches	
□High Blood Pressure	□Numbness	
□Palpitations/Skipped Beats	□Memory Loss	
□Rheumatic Fever	□Other	
□Mitral Valve Prolapse		
(Need antibiotics before dental procedures? □Yes □No		
□Other		

Family History

Relation	Living		Cause of death	Age at death
Mother	Yes (age_____)	No		
Father	Yes (age_____)	No		
Brother(s)	Yes (age_____)	No		
	Yes (age_____)	No		
	Yes (age_____)	No		
Sister(s)	Yes (age_____)	No		
	Yes (age_____)	No		
	Yes (age_____)	No		
Maternal Grandmother	Yes (age_____)	No		
Maternal Grandfather	Yes (age_____)	No		
Paternal Grandmother	Yes (age_____)	No		
Paternal Grandfather	Yes (age_____)	No		

Disorders in Your Family

Disorder	Relationship to You		
Breast cancer	☐Yes	☐No	☐Don't Know
Ovarian cancer	☐Yes	☐No	☐Don't Know
Colon cancer	☐Yes	☐No	☐Don't Know
Other cancer	☐Yes	☐No	☐Don't Know
Diabetes	☐Yes	☐No	☐Don't Know
Thyroid problems	☐Yes	☐No	☐Don't Know
Heart disease	☐ Yes	☐No	☐Don't Know
Blood clots	☐ Yes	☐No	☐Don't Know
Obesity	☐Yes	☐No	☐Don't Know
Psychiatric problems	☐Yes	☐No	☐Don't Know
Tuberculosis	☐Yes	☐No	☐Don't Know
Endometriosis	☐Yes	☐No	☐Don't Know
Infertility	☐ Yes	☐No	☐Don't Know
Menopause before age 40	☐Yes	☐No	☐Don't Know
Birth defects	☐Yes	☐No	☐Don't Know
Cystic Fibrosis	☐Yes	☐No	☐Don't Know
Tay-Sachs disease	☐Yes	☐No	☐Don't Know
Canavan disease	☐Yes	☐No	☐Don't Know
Bloom syndrome	☐Yes	☐No	☐Don't Know
Gaucher disease	☐Yes	☐No	☐Don't Know
Niemann-Pick disease	☐ Yes	☐No	☐Don't Know
Fanconi Anemia	☐Yes	☐No	☐Don't Know
Familial Dysautonia	☐Yes	☐No	☐Don't Know
Muscular Dystrophy	☐Yes	☐No	☐Don't Know
Neurologic (Brain/Spine)	☐Yes	☐No	☐Don't Know
Neural Tube defects	☐Yes	☐No	☐Don't Know
Bone/Skeletal defects	☐Yes	☐No	☐Don't Know
Dwarfism	☐ Yes	☐No	☐Don't Know
Developmental delay	☐Yes	☐No	☐Don't Know
Learning problems	☐ Yes	☐No	☐Don't Know
Polycystic kidney disease	☐Yes	☐No	☐Don't Know
Heart defect from birth	☐Yes	☐No	☐Don't Know
Down syndrome	☐Yes	☐No	☐Don't Know
Other chromosome defects	☐Yes	☐No	☐Don't Know

FERTILITY PARTNERSHIP

Infertility History – Female History (cont.)

2.7

Marfan syndrome	☐Yes	☐No	☐Don't Know
Hemophilia	☐Yes	☐No	☐Don't Know
Sickle Cell Anemia	☐Yes	☐No	☐Don't Know
Thalassemia	☐Yes	☐No	☐Don't Know
Galactosemia	☐Yes	☐No	☐Don't Know
Deafness/Blindness	☐Yes	☐No	☐Don't Know
Color Blindness	☐Yes	☐No	☐Don't Know
Hemochromatosis	☐Yes	☐No	☐Don't Know
None of the above	☐Yes	☐No	☐Don't Know
Other (Specifiy)			

This form was developed by the **American Society for Reproductive Medicine** to assist physicians and patients in obtaining a complete infertility history.

/ /

Signature **Date**

I confirm that I have reviewed the information above.

/ /

Physicians Signature **Date**

FERTILITY PARTNERSHIP

Patient Registration Male

A.1

Patient Information

Name (Last, First, Middle Initial)			Date of Birth	Social Security Number
Address	City	State		Zip Code
Email Address				Cell Phone
Employer	Occupation			Alt. Phone Number
Employment Address	City	State	Zip	Work Phone
Referring Physician	City		State	
How did you hear about our practice?				
Spouse's Name			Date of Birth	Social Security Number
Address ☐ **(Check if same as above)**	City	State		Zip Code
Employer	Occupation			Cell Phone
Employment Address	City	State	Zip	Alt. Phone Number

Insurance Information

Provider Name		Effective Date	Relationship _____Self _____Spouse
Insurance Co. Address	City	State	
Member ID Number	Group Number	Expiration Date	
Secondary Insurance Co.Name			Relationship _____Self _____Spouse
Secondary Insurance Co. Address	City	State	
Secondary Insurance Member ID Number	Group Number	Effective Date	

FERTILITY PARTNERSHIP

Patient Registration (Cont.)

A.2

Patient's Responsibilities:

I understand that as the patient, parent, or guardian, I am legally responsible for payment of all charges relating to my care. Patient and/or guarantor(s) agree to pay responsible attorney's fees and cost of **Patient's Certification, Authorization to Release Information and Payment Request**: I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to the insurance company or its representatives, any information needed for this or other insurance claim. In consideration of services rendered, I transfer and assign to the Fertility Partnership, any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent.

/ /

Patient Signature Date

FERTILITY PARTNERSHIP

Authorization of Medical Information

B.1

Please read the following questions carefully and sign at the bottom

1. May we leave a voicemail about your medical information on your cellular device? .....□ Yes □ No
2. May we contact you via text? .....□ Yes □ No
3. May we leave a message at your place of employment to contact this office? .....□ Yes □ No
4. May we contact you by email? .....□ Yes □ No

   Email address: _____
5. May we discuss your medical condition/results with members of your family or spouse/partner?..... ..... □ Yes □ No

If yes to question 5, please list below the name of that person(s) and their relationship to you:
(For Example, if you are ok with a spouse calling for your results, list them below)

Name of Person (please print)	**Relationship to Patient** (please print)
Example: Jane Doe	*Wife*

Please list any information from your chart at Fertility Partnership and their staff to release information **NOT** wish to have disclosed:

_____

_____

_____

I understand that I will need to sign a separate records release form to release any/all medical records to myself or any other treating physician.

I have read and received the Fertility Partnership's Notice of Privacy Practices.

_____ / /

Patient or Legal Guardian's Signature Date

This release may be rescinded at any time in writing. The Fertility Partnership cannot guarantee your request will be honored to the fullest. In the event of an emergency, Fertility Partnership will disclose information that is related to your emergency condition.

FERTILITY PARTNERSHIP

Infertility History Male

1.0

Male Medical History and Information

- Have you been evaluated by a Urologist? □ No □ Yes
- Have you previously conceived with another woman? □ No (Birth control used? □No □Yes)
  □ Yes (How many times? _____
- Have you had a Semen Analysis? □ No □ Yes
- Do you have difficulty with erections? □ No □ Yes
- Do you have retrograde ejaculation of sperm into the bladder? □ No □ Yes

Have you had any of the following sexually transmitted diseases or pelvic infections? *(Check all that apply)*

□ Chlamydia (Date _____) □ Gonorrhea (Date _____) □ Herpes (Date _____) □ Genital Warts/HPV (Date _____)
□ Syphilis (Date _____) □ HIV/AIDS (Date _____) □ Hepatitis (Date _____) □ Other (Date _____)

- Have you had a history of undescended testicles? □ No □ Yes
- Do you have scrotal or testicular pain? □ No □ Yes
- Did you have the mumps after puberty? □ No □ Yes
- Have you had prior injury to your testicles requiring surgery? □ No □ Yes

Have you been diagnosed with any of the following diseases?

□ Diabetes Mellitus.....□ No □ Yes □ Cancer.....□ No □ Yes
□ Multiple Sclerosis.....□ No □ Yes □ other neurologic problems .....□ No □ Yes
□ Prostatic Infection.....□ No □ Yes □ Urinary Infections.....□ No □ Yes
□ High blood pressure.....□ No □ Yes (any medications?) _____

- Have you had any fever in the last 3 months? □ No □ Yes
- Have you had a vasectomy? □ No □ Yes
  If yes, have had a vasecto0my reversal? □ No □ Yes
- Have you had surgery for varicocele repair? □ No □ Yes
- Have you had hernia surgery? □ No □ Yes
- Did you undergo any bladder or penis surgery as a child? □ No □ Yes
- Are you exposed to prolonged heat in the workplace? □ No □ Yes
- Have you had chemotherapy for cancer? □ No □ Yes
- Are you allergic to any medications? □ No □ Yes
  If yes, please list and describe reactions:

_____

_____

_____

_____

FERTILITY PARTNERSHIP

Infertility History Male

1.0

Male Medical History and Information (cont.)

- List any current medication(s) _____
- List any current medical problem(s) _____
- How many caffeinated beverages (coffee, soda, tea) do you drink per day? _____ □None
- Do you smoke cigarettes? □ No □ Yes (#/day _____) How many years? _____ □ Quit (When?) _____
- Do you drink alcohol? □ No □ Yes □Beer (#/day _____) □Wine (#/day _____) □Liquor (#/day _____)
- Do you use marijuana, cocaine or any other similar drug? □No □Yes (describe) _____
- Do you take any herbal medicines/vitamins or health food store supplements? □No □Yes (Please List)_____
- Are you aware of any radiation/toxic material exposures other than X-Rays? □No □Yes (describe) _____
- Do you use hot tubs regularly? □ No □ Yes
- Did your mother take DES when she was pregnant with you? □ No □ Yes □ Don't Know
- Have any of your immediate members had difficulty conceiving a child? □ No □ Yes (describe) _____

Disorders in your Family

Disorder	Relationship to you		
Cystic Fibrosis	□ Yes	□ No	□ Don't know
Tay-Sachs Disease	□ Yes	□ No	□ Don't know
Canavan Disease	□ Yes	□ No	□ Don't know
Bloom Syndrome	□ Yes	□ No	□ Don't know
Gaucher Disease	□ Yes	□ No	□ Don't know
Niemann-Pick Diseae	□ Yes	□ No	□ Don't know
Fanconi Anemia	□ Yes	□ No	□ Don't know
Familial Dysautonia	□ Yes	□ No	□ Don't know
Muscular Dystrophy	□ Yes	□ No	□ Don't know
Neuroloogic (brain/spine)	□ Yes	□ No	□ Don't know
Neural Tube defects	□ Yes	□ No	□ Don't know
Bone/Skeletal defects	□ Yes	□ No	□ Don't know
Dwarfism	□ Yes	□ No	□ Don't know
Developmental delay	□ Yes	□ No	□ Don't know
Learning problems	□ Yes	□ No	□ Don't know
Polycystic kidney disease	□ Yes	□ No	□ Don't know
Heart defect from birth	□ Yes	□ No	□ Don't know
Down Syndrome	□ Yes	□ No	□ Don't know
Other chromosome defects	□ Yes	□ No	□ Don't know
Marfan syndrome	□ Yes	□ No	□ Don't know
Hemophilia	□ Yes	□ No	□ Don't know
Sickle Cell Anemia	□ Yes	□ No	□ Don't know

FERTILITY PARTNERSHIP

Infertility History Male

1.0

Thalassemia	□ Yes	□ No	□ Don't know
Galactosemia	□ Yes	□ No	□ Don't know
Deafness/Blindness	□ Yes	□ No	□ Don't know
Color Blindness	□ Yes	□ No	□ Don't know
Hemochromatosis	□ Yes	□ No	□ Don't know
□ **None of the above**			
□ Other (specify)			

What is your Ancestry?			**Would you like to be screened for.....**
□ African-American	□ Cajun/French Canadian	□ Northern European	□ Cystic Fibrosis □ Yes □ No
□ American Indian/Native American	□ Caucasian	□ Southern European	□ Sickle Cell Anemia □ Yes □ No
□ Ashkenazi Jewish	□ Eastern European	□ Other (specify)	□ Tay-Sachs Disease □ Yes □ No
□ Asian-American	□ Hispanic/Caribbean		□ Thalassemia □ Yes □ No

This form was developed by the **American Society for Reproductive Medicine** to assist physicians and patients in obtaining a complete infertility history.

_____ / /

Signature **Date**

I confirm that I have reviewed the information above.

_____ / /

Physicians Signature **Date**

FERTILITY PARTNERSHIP

Notice of Privacy Practices

F.1

This notice described how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The terms of this notice applies to D. Elan Simckes, M.D. and the Fertility Partnership. This notice is intended to inform you about our practice related to your medical records. It will explain how Dr. Simckes and the Fertility Partnership may use and disclose your medical information, our obligation related to the use and disclosure of your medical information, and your rights related to any medical information that we have about you. We have listed some of the reasons why we might use or disclose your medical information with some examples. Not every potential use or discussed, but all of the ways that we are allowed to use and disclose information falls into one of the categories below.

Use and Disclosure of Medical Information

For Treatment

To provide you with medical treatment or services, we need to use or disclose information about you to personnel involved in your treatment. For example, a physician may need to consult with another provider regarding your condition while providing care.

For Payment

We may use and disclose your medical information to bill and receive payment for the treatment that you received. For example, we may use or disclose your medical information to your insurance company about a service that you received so that your insurance company can pay us reimburse you for the service.

For Healthcare Operations

We can use and disclose medical information about your our operations. For example, we may use or disclose medical information about you for insurance compliance reviews.

Uses and Disclosures of Medical Information that Do NOT Require Your Authorization

We can use or disclose health information about you without your authorization when there is an emergency, when we are required by law to treat you, or when we are requires by law to use or disclose certain information. We may use or disclose your health information without your authorization in any of the following circumstances:

- When it is required by federal, states or other law;
- When it is needed for public health activities;
- When reporting information about victims of abuse, neglect, or domestic violence;
- When reporting information for the purpose of health oversight activities;
- When reporting information for judicial and administrative proceedings;
- When reporting information for law enforcement purposes;
- When disclosing information about deceased persons to medical examiners, coroners, and funeral directors;
- When disclosing or using information for organ and tissue donation purposes;

FERTILITY PARTNERSHIP

Patient's Right and Responsibilities

G.1

As a patient you have certain right and responsibilities. We recognize that a respectful relationship between the healthcare provider and the patient is the foundation of proper medical care. Copies of this statement are posted in our patient waiting areas.

Patients have the RIGHT to:

- Receive humane care and treatment, with respect and consideration;
- Privacy and confidentiality when seeking or receiving care except for life threatening conditions or situations;
- Confidentiality of your health records
- Be informed of and to exercise the opinion to refuse to participate in any research aspect of your are without compromising access to medical care and treatment;
- Receive accurate information concerning diagnosis, treatment, risks involved and prognosis of an illness or health related condition;
- Ask about reasonable alternatives to care;
- A second opinion regarding one's health care and treatment;
- Participate actively in decisions regarding one's health care and treatment;
- Accessible information regarding the scope and availability of services; and
- Be informed about legal reporting requirements regarding any aspect of screening or care.

Patients have the RESPONSIBILTY to:

- Provide complete information about ones' illness/problem, to enable proper evaluation and treatment;
- Ask questions so that an understanding of the condition or problem is ensured;
- Show respect to health personnel and other patients;
- Reschedule/cancel an appointment so hat another may be given that time slot;
- Use prescription or medical devices for oneself only; and
- Inform the practitioner(s) if one's condition worsens or an expected reaction occurs from a medication.

Appointment cancellation

We understand that there may be situations that make it challenging for you to keep your appointment. If you are unable to keep your appointment with us **please call** 636.441.7770 to cancel or reschedule.
Our EMR system will automatically issue a $50 "NO CALL/NO SHOW" fee to patients who have not called to reschedule their appointment.

Records Release Policy

A "Records Release" authorization form must be completed to release your medical information to you or a third party.

A $15 fee will be charged for each request. Charts over 50 pages will be charged an additional .15 cents per page. Please note turnaround time may be up to 14 days.

Payments

We accept cash, credit/debit cards, major credit cards excluding American Express.

The CDC recently reported Fertility Partnership as one of the TOP PROGRAMS in Missouri.

Please browse through our website at www.Fertilitypartnership.com for more information about our practice. Thank you!