



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
Referring Physician		City		State
How did you hear about our practice?				
Spouse's Name		Date of Birth	Social Security Number	
Address <input type="checkbox"/> (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



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



Authorization of Medical Information

8-1

(NOTE: The patient/legal guardian should fill out this form)

Please read the following questions carefully and sign at the bottom

- 1. Does your cellular device or household have an answering machine?
2. If yes, may we leave a message on it?
3. May we leave a message at your place of employment to contact this office?
4. May we discuss the patient's medical condition with members of your family or friends who may contact the office regarding the patient?
5. May we contact you by email?
Email address:

If yes to question 4, please list below the name of that person(s) and their relationship to the patient:

Table with 2 columns: Name of Person (please print), Relationship to Patient (please print). Includes three rows of blank lines for input.

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

Three horizontal lines for listing information to be 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.



FP# _____

Patients Pharmacy Information

Please Print

_____/_____/_____
Patient's Name: **Last, First** & Date of Birth

Address & Phone Number

Pharmacy Name & Location

Phone: _____ Fax: _____

Pharmacy Phone Number & Fax Number



Consent to Process Insurance

CI

PLEASE CHECK ONE

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 _____.
(Name of insurance)

Or

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

Print Name

Signature

___/___/2020
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

____ / ____ / 2020
Date



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 _____



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.				<input type="checkbox"/> Yes <input type="checkbox"/> No
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No
4.				<input type="checkbox"/> Yes <input type="checkbox"/> No
5.				<input type="checkbox"/> Yes <input type="checkbox"/> No
6.				<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

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
-

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

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 <input type="checkbox"/> Yes <input type="checkbox"/> No
American Indian/Native American	Caucasian	Southern European	Sickle Cell Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
Ashkenazi Jewish	Eastern European	Other (specify)	Tay-Sachs Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Asian-American	Hispanic/Caribbean		Thalassemia <input type="checkbox"/> Yes <input type="checkbox"/> No

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

Cardiovascular	Neurological Problems	
<input type="checkbox"/> None	<input type="checkbox"/> None	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Weakness	
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Seizers/Epilepsy	
<input type="checkbox"/> Stroke	<input type="checkbox"/> Headaches	
<input type="checkbox"/> Murmurs	<input type="checkbox"/> Migraine Headaches	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Numbness	
<input type="checkbox"/> Palpitations/Skipped Beats	<input type="checkbox"/> Memory Loss	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other	
<input type="checkbox"/> Mitral Valve Prolapse		
(Need antibiotics before dental procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Ovarian cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Colon cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Other cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Thyroid problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Psychiatric problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Menopause before age 40	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Birth defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Cystic Fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Tay-Sachs disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Canavan disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Bloom syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Gaucher disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Niemann-Pick disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Fanconi Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Familial Dysautonomia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Muscular Dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Neurologic (Brain/Spine)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Neural Tube defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Bone/Skeletal defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Dwarfism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Learning problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Polycystic kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Heart defect from birth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Down syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Other chromosome defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know



Infertility History – Female History (cont.)

2-7

Marfan syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Thalassemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Galactosemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Deafness/Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Color Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Hemochromatosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
None of the above	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know
Other (Specify)			

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



Patient Registration **Male**

01

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
Referring Physician		City		State
How did you hear about our practice?				
Spouse's Name		Date of Birth	Social Security Number	
Address <input type="checkbox"/> (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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse
Insurance Co. Address		City	State
Member ID Number		Group Number	Expiration Date
Secondary Insurance Co. Name			Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse
Secondary Insurance Co. Address		City	State
Secondary Insurance Member ID Number		Group Number	Effective Date



Patient Registration (Cont.)

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



Authorization of Medical Information

B.1

(NOTE: The patient/legal guardian should fill out this form)

Please read the following questions carefully and sign at the bottom

- 1. Does your cellular device or household have an answering machine? Yes No
 - 2. If yes, may we leave a message on it? Yes No
 - 3. May we leave a message at your place of employment to contact this office? Yes No
 - 4. May we discuss the patient's medical condition with members of your family or friends who may contact the office regarding the patient? Yes No
 - 5. May we contact you by email? Yes No
- Email address: _____

If yes to question 4, please list below the name of that person(s) and their relationship to the patient:

Name of Person (please print)	Relationship to Patient (please print)
_____	_____
_____	_____
_____	_____

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.

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 _____) Gonorrhoea (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 vasectomy 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:

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Tay-Sachs Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Canavan Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Bloom Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Gaucher Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Niemann-Pick Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Fanconi Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Familial Dysautonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Muscular Dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Neurologic (brain/spine)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Neural Tube defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Bone/Skeletal defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Dwarfism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Learning problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Polycystic kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Heart defect from birth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Down Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Other chromosome defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Marfan syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know



Infertility History

Male

1.0

Thalassemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Galactosemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Deafness/Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Color Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Hemochromatosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
<input type="checkbox"/> None of the above			
<input type="checkbox"/> Other (specify)			

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



Notice of Privacy Practices

F-1

This notice describes 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 apply to Dr. 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 disclosure, 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 or reimburse you for the service.

For Healthcare Operations

We can use and disclose medical information about you for 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 required 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, state 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;

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 care 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 RESPONSIBILITY 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!