Coastal Fertility Medical Center | RSMC

Patient Forms

Contact Information

Patient

First Name: _____	**Last Name: _____**	**Middle Initial: _____**	**Marital Status: _____**
Best Ph # To Reach You: _____	**OK to leave a message?:** Yes ☐ No ☐	**2nd Best Ph # To Reach You: _____**	**OK to leave a message?:** Yes ☐ No ☐
Date Of Birth: _____	**E-mail: _____**	**Age: _____**	**Address: _____**
City: _____	**State: _____**	**Zip Code: _____**	**DRIVER'S LIC: _____**
State: _____	**Occupation: _____**	**Work Hours: _____**	**Employer: _____**
City: _____	**State: _____**	**Zip Code: _____**	

Do You have Partner ?: Yes ☐ No ☐

Partner

First Name: _____	**Last Name: _____**	**Middle Initial: _____**	**Marital Status: _____**
Best Ph # To Reach You: _____	**OK to leave a message?: _____**	**2nd Best Ph # To Reach You: _____**	**OK to leave a message?: _____**
Address: _____	**City: _____**	**State: _____**	**Zip Code: _____**
Date Of Birth: _____	**Age: _____**	**DRIVER'S LIC: _____**	**ST: _____**
E-mail: _____	**Occupation: _____**	**Work Hours: _____**	**Employer: _____**
Employer Address: _____	**City: _____**	**State: _____**	**Zip Code: _____**

Yes ☐ No ☐

Referral information

WHOM MAY WE THANK FOR THIS REFERRAL? Physician ☐ Friend ☐ Seminar ☐ Internet ☐ Support Group ☐
Physician (Name): _____

Insurance information

Patient

PRIMARY INS: _____	**Insured's Name: _____**	**Insurance ID: _____**

Type : HMO ☐ PPO ☐ POS ☐ EPO ☐ OTHER ☐		
WHICH MEDICAL GROUP ARE YOU ASSIGNED TO?: _____	**ID#:** ____	**GRP #:** _____
CLAIMS ADDR: _____	**City:** _____	**State:** _____
Zip Code: _____	**Phone:** _____	
Do You have Partner?: Yes ☐ No ☐	**PRIMARY INS:** if Yes_____	
Emergency contact person (not living with you): ____	**Relationship:** _____	**Insured's Name:** _____
Insured: HMO ☐ PPO ☐ POS ☐ EPO ☐ OTHER ☐		
WHICH MEDICAL GROUP ARE YOU ASSIGNED TO?: _____	**ID#:** ____	**GRP #:** ____
CLAIMS ADDR: _____	**City:** _____	**State:** _____
Zip Code: _____	**Phone:** _____	
Do you have document to upload?: Yes ☐ No ☐		
Upload Front Insurance: _____		
Upload Back Insurance: _____		
Patient's signature: _____		**Date:** _____
Partner's signature: _____		**Date:** _____

Coastal Fertility Medical Center | RSMC

Infertility History

Has a Uterus

First Name: _____	**Middle Initial:** dfdfvd _____	**Last Name:** _____	**Age:** _____
Date of Birth: _____	**Occupation:** _____	**Home Street Address:** _____	**City:** _____
State: _____	**Zip/Postal Code:** _____	**Country:** _____	**E-mail:** _____

PATIENT MEDICAL HISTORY AND INFORMATION

Reason for Visit: Infertility Evaluation ☐ Sperm Insemination ☐ Other ☐
Reason for Visit (Other)_____

What are your expectations for this visit?: _____

Any questions you wish to address: _____

Do you have any personal, ethical, or relations 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.?: Yes ☐ No ☐

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

Pregnancy History

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?: _____

Number of Premature (less than 37 weeks) Deliveries : _____

How many were stillborn?: _____

Any Pregnancies with Birth Defects?: Yes ☐ No ☐
If Yes, Please Specify_____

Pregnancy History Details	Months to Conception	Treatments to Conceive	Delivery Type/D&C/Complications	Current Partner? (Yes/No)
_____	_____	_____	_____	_____

Menstrual Cycle History

Menstrual cycle pattern (check all that apply):

☐ Regular periods
☐ Irregular periods
☐ Spotting before periods
☐ No periods
☐ Heavy periods
☐ Light periods
☐ Bleeding between periods

Number of days between the start of one period to the start of the next period: _____

How many days of bleeding do you have?: _____

Age when you had your first period: _____

Age when you first noticed: Breast development (years): _____

Age when you first noticed: Pubic hair (years): _____

Age when you first noticed: Underarm hair (years): _____

How many periods do you have per year?: _____

If you do not have periods, at what age did you stop having them?: _____

Do you have severe cramping or pelvic pain with your periods?: Yes ☐ No ☐
Always __ Sometimes __ Recently __In the past: _____

Contraceptives Methods (History)

Do you use or have you used any contraceptives?: Yes ☐ No ☐

	Method	When they started?	Are you still using contraceptives	When they stopped?
☐	Condoms			
☐	Diaphragm	____	Yes ☐ No ☐	___
☐	IUD	____	Yes ☐ No ☐	___
☐	Birth control pills	____ **Complications: ____**	Yes ☐ No ☐	
☐	Inject able contraception	____ **Complications: ____**	Yes ☐ No ☐	___

☐	Skin patch	_____	Yes ☐ No ☐	__
☐	Foam or Jelly	_____	Yes ☐ No ☐	__
☐	Tubal sterilization procedure (tubes tied)	_____	Yes ☐ No ☐	__
☐	Tubes untied	_____	Yes ☐ No ☐	__

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?: Yes ☐ No ☐

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 types?: _____

Pap Smear Medical History

When was your last pap smear (month and year)?: _____

When was your last abnormal pap smear?: _____

Have you undergone any procedures as a result of an abnormal pap smear?: Yes ☐ No ☐

Yes (check all that apply):

☐ Colposcopy
☐ Cryosurgery (Freezing)
☐ Laser treatmen
☐ Conization
☐ Leep procedure

Breast Screening History

Have you ever had a mammogram?: Yes ☐ No ☐

Date	Result
_____	_____

Do you perform self breast exams?: Yes ☑ No ☑

Medical History

Are you allergic to any medications?: Yes ☐ No ☐

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

Do you take any medication?: Yes ☐ No ☐
If yes, please list: _____

Do you take any herbal medicines/vitamins or health food store supplements?: Yes ☐ No ☐
If yes, please list: _____

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

Did you have either of these childhood illnesses?:

☐ Chickenpox (Varicella)
☐ German Measles (Rubella)
☐ Don't know
☐ Other childhood diseases
If Other childhood diseases: _____

Vaccinations

Chickenpox (Varicella)	MMR - Measles, Mumps, and Rubella (German Measles)	BCG (Tuberculosis)	Hepatitis B	Polio	Influenza
☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Social History

How many caffeinated beverages (coffee, tea, soda) do you drink per day?: _____

Do you smoke cigarettes?: Yes ☐ No ☐
How many/day?: _____

Do you drink alcohol?: Yes ☐ No ☐

☐ Beer - # per week
☐ Wine - # per week
☐ Liquor - # per week

Do you use marijuana, cocaine, or any other similar drug?: Yes ☐ No ☐
If Yes please describe _____

Do you exercise?: Yes ☐ No ☐
If Yes please describe _____

Are you aware of any radiation exposures other than X-rays?: Yes ☐ No ☐
If Yes please describe _____

Physician Notes (for office use only): _____

Surgical History

Have you had any surgeries?: Yes ☐ No ☐
Number of surgeries: _____

Year	Type of surgery in chronological
_____	_____

Did you have any anesthesia problems?:

Physical Symptoms

- **General:**

☐ Diabetes
☐ Hair loss
☐ Anorexia/Bulimia
☐ Lack of energy
☐ Fever/chills
☐ Other
☐ None

Describe so it's consistent with the others – do for all similar responses : _____

- **Head, Eyes, Ears, Nose, and Throat:**

☐ Dizziness
☐ Loss of sense of smell
☐ Headaches
☐ Chronic nasal congestion
☐ Blurred vision
☐ Hearing loss/deafness
☐ Other
☐ None

Describe so it's consistent with the others – do for all similar responses : _____

- **Respiratory:**

☐ Shortness of breath
☐ Asthma

- [ ] Bronchitis
- [ ] Pneumonia
- [ ] Tuberculosis
- [ ] Bloody cough
- [ ] Other
- [ ] None

Describe so it's consistent with the others – do for all similar responses : _____

- **Endocrine/Hormona:**

  - [ ] Recent weight gain or loss
  - [ ] Thyroid gland problems
  - [ ] Rapid weight gain or loss
  - [ ] Excessive hunger/thirst
  - [ ] Temperature intolerance-hot flashes or feeling cold
  - [ ] Other
  - [ ] None

  Describe so it's consistent with the others – do for all similar responses : _____

- **Breasts:**

  - [ ] Discharge
  - [ ] Lumps
  - [ ] Abnormal mammogram
  - [ ] Reduction
  - [ ] Augmentation/Breast Implants
  - [ ] Other
  - [ ] None

  Describe so it's consistent with the others – do for all similar responses : _____

- **Neurological Problems:**

  - [ ] Weakness/Loss of balance
  - [ ] Seizures/Epilepsy
  - [ ] Headaches
  - [ ] Migraine headaches
  - [ ] Numbness
  - [ ] Memory Loss
  - [ ] Other
  - [ ] None

  Describe so it's consistent with the others – do for all similar responses : _____

- **Gastrointestinal:**

  - [ ] Nausea/Vomiting
  - [ ] Ulcers
  - [ ] Hepatitis
  - [ ] Diarrhea

- [ ] Blood in your stools
- [ ] Irritable Bowel Syndrome
- [ ] Change in bowel habits
- [ ] Colitis (ulcerative or Cohn's)
- [ ] Other
- [ ] None

Describe so it's consistent with the others – do for all similar responses : _____

- **Genito-Urinary:**

- [ ] Bladder infections
- [ ] Kidney infections
- [ ] Vaginal infections
- [ ] Frequent urination
- [ ] Blood in the urine
- [ ] Leaking Urine
- [ ] Herpes
- [ ] Other
- [ ] None

Describe so it's consistent with the others – do for all similar responses : _____

- **Skin/Extremities:**

- [ ] Unexplained rash/inflammation
- [ ] Acne
- [ ] Skin caner
- [ ] Burn injury
- [ ] Moles changing in appearance
- [ ] Excess hair growth
- [ ] Other
- [ ] None

Describe so it's consistent with the others – do for all similar responses : _____

- **Musculoskeletal:**

- [ ] Unusual muscle weakness
- [ ] Decreased energy/stamina
- [ ] Rheumatoid arthritis
- [ ] Lupus Erythematosus
- [ ] Myasthenia gravis
- [ ] Other
- [ ] None

Describe so it's consistent with the others – do for all similar responses : _____

- **Hematologic:**

- [ ] Blood clotting disorder/Blood clot
- [ ] Sickle Cell Anemia

- ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions
- ☐ Other
- ☐ None

Describe so it's consistent with the others – do for all similar responses : _____

- **Cardiovascular:**

- ☐ Palpitations/Skipped beats
- ☐ Chest pain
- ☐ Heart attack
- ☐ Stroke
- ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse
- ☐ Other
- ☐ None

Describe so it's consistent with the others – do for all similar responses : _____

- **Mental Health Problems:**

- ☐ Depression
- ☐ Anxiety disorder
- ☐ Schizophrenia
- ☐ Other
- ☐ None

Describe so it's consistent with the others – do for all similar responses : _____

Family History

Mother (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Father (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Brother (s) (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Sister (s) (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Maternal Grandmother (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Maternal Grandfather (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Paternal Grandmother (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

Paternal Grandfather (Living): Yes ☐ No ☐

If Yes, Age___

If No, Cause of Death___

What is your Ancestry?:

Disorders in Your Family

Medical Disorders	Yes/No/Don't Know	If yes, please list relationship to you
Breast cancer	_____	_____
Ovarian cancer	_____	_____
Other cancer	_____	_____
Diabetes	_____	_____
Thyroid Problems	_____	_____
Heart Disease	_____	_____
Blood Clots	_____	_____
Obesity	_____	_____
Psychiatric problems	_____	_____

Tuberculosis	_____	_____
Infertility	_____	_____
Menopause before age 40	_____	_____
Birth Defects	_____	_____
Cystic Fibrosis	_____	_____
Tay-Sachs disease	_____	_____
Canavan disease	_____	_____
Bloom Syndrome	_____	_____
Gaucher disease		
Neimann-Pick disease	_____	_____
Fanconi Anemia	_____	_____
Familiar Dysautonia	_____	_____
Muscular Dystrophy	_____	_____
Neurologic brain/spine	_____	_____
Neural Tube Defects	_____	_____
Bone/Skeletal Defects	_____	_____
Dwarfism	_____	_____
Developmental Delay	_____	_____
Learning problems	_____	_____
Polycystic kidneydisease	_____	_____
Marfan syndrome	_____	_____
Hemophilia	_____	_____
Sickle Cell anemia	_____	_____
Thalassemia	_____	_____
Galactosemia	_____	_____
Deafness/Blindness	_____	_____
Color/Blindness	_____	_____
Hemochromatosis	_____	_____

PRIOR INFERTILITY TESTING AND TREATMENT

Have you had prior infertility testing or treatment elsewhere?:

Yes ☐ No ☐

Prior Tests (check all that apply):

	Prior Tests	Date	Results
☐	Basal body temperature chart	_____	_____
☐	Thyroid test	_____	_____
☐	Ovulation test	_____	_____
☐	Day 3 blood test for FSH level	_____	_____
☐	Hysterosalpingogram (HSG)	_____	_____
☐	Laparoscopy	_____	_____
☐	Hysteroscopy surgery	_____	_____
☐	Progesterone blood test	_____	_____
☐	Prolactin blood test kit	_____	_____
☐	Prolactin blood test kit	_____	_____

Prior Treatment (Check all that apply):

☐ **Intrauterine insemination**

No. of cycles: _____

List

Dates (MM/YY to MM/YY)	Outcome
_____	_____

☐ **Clomiphene citrate with timed intercourse**

No. of cycles: _____

List

Dates (MM/YY to MM/YY)	Outcome
_____	_____
_____	_____

☐ **Daily fertility drug injections with insemination**

No. of cycles: _____

List

Dates (MM/YY to MM/YY)	Outcome
_____	_____

☐ **Completed in vitro fertilization cycle(s)**

No. of cycles: _____

# of eggs	# of embryos transferred	# frozen
_____	_____	_____

List

Dates (MM/YY to MM/YY)	Outcome
_____	_____

☐ **Frozen embryo transfers**

No. of cycles: _____

List

Dates (MM/YY to MM/YY)	Outcome
_____	_____

# of eggs	# of embryos transferred	# frozen
_____	_____	_____

☐ **None of these**

Any other prior treatment (describe): _____

Additional Information/Complications: _____

EMOTIONAL STATUS

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures: _____

Do you see a counselor?: Yes ☐ No ☐

For how long?: _____

How often?: _____

List any anti-depressant/anti-anxiety medications you are currently taking?: _____

Describe any emotional, marital, or sexual problems caused by your infertility: _____

PATIENT'S SIGNATURE

_____

Date (Patient): _____

Indicate which number to call or leave messages

Phone (Home): _____

Phone (Work): _____

Do you have a spouse/partner? : Yes ☐ No ☐ other ☐
Please Specify:_____

Spouse/Partner

First Name: _____

Last Name: _____

Age: _____

Date of Birth (MM/DD/YY): _____

Occupation: _____

Home Street Address: _____

City: _____

State: _____

Zip/Postal Code: _____

Country: _____

Physician Notes (For office use only): _____

Who is your Ob/Gyn?

Name: _____

Phone: _____

Who is your Primary Care Physician?

Name: _____

Phone: _____

PARTNER MEDICAL HISTORY AND INFORMATION

My partner has a penis

List current medications : _____

List any current medical problem(s): _____

How many caffeinated beverages (coffee, tea, soda) do you drink per day?: _____

Do you smoke cigarettes?: Yes ☐ No ☐
How many/day?: _____ **How many years ?:** _____

Do you drink alcohol?: Yes ☐ No ☐
If you drink alcohol:

☐ Beer
☐ Wine
☐ Liquor

Per week: _____

Do you use marijuana, cocaine, or any other similar drug?: Yes ☐ No ☐
If Yes, please describe: _____

Do you exercise?: Yes ☐ No ☐
If Yes, please describe: _____

Are you aware of any radiation exposures other than X-rays?: Yes ☐ No ☐
If Yes, please describe: _____

Physician Notes (for office use only): _____

Have you been evaluated by a urologist?: Yes ☐ No ☐

Have you previously conceived with another woman?: Yes ☐ No ☐
How many times? _____

Have you had a semen analysis?: Yes ☐ No ☐

Do you have difficulty with erections?: Yes ☐ No ☐

Do you have retrograde ejaculation of sperm into the bladder?: Yes ☐ No ☐

Have you had any of the following sexually transmitted diseases or pelvic infections?: Yes ☐ No ☐

Check all that apply:
☐ Chlamydia
☐ Gonorrhea
☐ Herpes
☐ Genital warts/HPV
☐ Syphilis
☐ HIV/AIDS
☐ Hepatitis
☐ Other
If Other, Please Describe: _____

Have you had a history of undescended testicles?: Yes ☐ No ☐

One side:	Both:	Date:
_____	_____	_____

Do you have scrotal or testicular pain?: Yes ☐ No ☐
Date: _____

Did you have the mumps after puberty?: Yes ☐ No ☐
Date: _____

Have you had prior injury to your testicles requiring hospitalization?: Yes ☐ No ☐
Date: _____

Have you had any fever in the last 3 months?: Yes ☐ No ☐
Date: _____

Have you been diagnosed with any of the following diseases?:

☐ Diabetes Mellitus
☐ Cancer
☐ Multiple Sclerosis
☐ Prostatic infections
☐ Urinary infections
☐ High Blood Pressure

Any medications?: _____

Have you had a vasectomy?: Yes ☑ No ☑
Date: _____

Have you had a vasectomy reversal?: Yes ☑ No ☑
Date: _____

Have you had surgery for varicocele repair?: Yes ☑ No ☑
Date: _____

Have you had hernia surgery?: Yes ☑ No ☑
Date: _____

Did you undergo any bladder or penis surgery as a child?: Yes ☑ No ☑
Date: _____

Are you exposed to prolonged heat in the workplace?: Yes ☑ No ☑
Date: _____

Are you exposed to any radiation or harmful chemicals in the workplace?: Yes ☑ No ☑
Date: _____

Have you had chemotherapy for cancer?: Yes ☑ No ☑
Date: _____

You allergic to any medications?: Yes ☑ No ☑
Date: _____ **Please list and describe reactions:** _____

Disorders in Your Family

Medical Disorders	Yes/No/Don't Know	If yes, please list relationship to you
Cystic Fibrosis	_____	_____
Tay-Sachs disease		_____
Canavan disease	_____	_____
Bloom Syndrome	_____	_____
Gaucher disease	_____	_____
Neimann-Pick disease	_____	_____
Fanconi Anemia	_____	_____
Familiar Dysautonia	_____	_____

Muscular Dystrophy	_____	_____
Paternal Grandmother	_____	_____
Paternal Grandfather	_____	_____
Neurologic brain/spine		_____
Neural Tube Defects	_____	_____
Bone/Skeletal Defects	_____	_____
Dwarfism	_____	_____
Developmental Delay	_____	_____
Learning problems	_____	_____
Polycystic kidney disease	_____	_____
Heart defect from birth	_____	_____
Down syndrome	_____	_____
Other chrom. defects	_____	_____
Marfan syndrome	_____	_____
Hemophilia	_____	_____
Sickle Cell anemia	_____	_____
Thalassemia	_____	_____
Galactosemia	_____	_____
Deafness/Blindness	_____	_____
Hemochromatosis		_____

None of the above; Other (Please specify): _____

SPOUSE PARTNER'S SIGNATURE : _____

Date(Partner): _____

Physician Notes (for office use only): _____

Coastal Fertility Medical Center | RSMC

Family History Questionnaire

Genetic Family History & Pregnancy Questionnaire

Date of Appointment: _____

Patient Information

Patient's Name: _____

Date Of Birth: _____

Occupation: _____

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Referring Physician's Name: _____

Referring Physician's Phone Number: _____

The following questions may help your doctor or genetic counselor complete a genetic risk assessment and determine if certain genetic tests are appropriate. If you are unsure about your family history, please speak with family members.

Patient	Partner	Both
☐ Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian ☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese ☐ Jewish, French Canadian or Cajun ☐ African American, African descent, Black, Puerto Rican, Caribbean or Central American ☐ Hispanic or Mexican ☐ Caucasian ☐ Other (specify)	☐ Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian ☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese ☐ Jewish, French Canadian or Cajun ☐ African American, African descent, Black, Puerto Rican, Caribbean or Central American ☐ Hispanic or Mexican ☐ Caucasian ☐ Other (specify)	☐ Chinese, Taiwanese, Asian Indian, Pakistani, Filipino or Southeast Asian ☐ Italian, Greek, Middle Eastern, Spanish, or Portuguese ☐ Jewish, French Canadian or Cajun ☐ African American, African descent, Black, Puerto Rican, Caribbean or Central American ☐ Hispanic or Mexican ☐ Caucasian ☐ Other (specify)

Have you, your partner or anyone in your families ever had the following conditions

Down Syndrome: Yes ☐ No ☐

Other Chromosome problems: Yes ☐ No ☐

Mental retardation, autism, or developmental delay: Yes ☐ No ☐

Spina bifida (open spine): Yes ☐ No ☐

Anencephaly (opening in head/brain): Yes ☐ No ☐

Blood disorder, such as hemophilia or sickle cell: Yes ☐ No ☐

Muscular dystrophy or neuromuscular disease: Yes ☐ No ☐

Cystic fibrosis: Yes ☐ No ☐

Neurofibromatosis: Yes ☐ No ☐

Skeletal disorder, like dwarfism: Yes ☐ No ☐

Polycystic kidney disease: Yes ☐ No ☐

Huntington disease or other adult neurological diseases (e.g. dementia, Alzheimer's: Yes ☐ No ☐

Heart defect: Yes ☐ No ☐

Cleft lip/cleft palate: Yes ☐ No ☐

Blindness/deafness: Yes ☐ No ☐

Baby who died at birth or within first year: Yes ☐ No ☐

Stillborn or 2 or more pregnancy losses: Yes ☐ No ☐

Any birth defect not in this list: Yes ☐ No ☐

Any other inherited (genetic) condition: Yes ☐ No ☐

Any other serious medical condition or surgery: Yes ☐ No ☐

Are you or your partner adopted?: Yes ☐ No ☐

Are you and your partner related to each other (other than by marriage)?: Yes ☐ No ☐

Is there a history of infertility in either you and /or your partner?: Yes ☐ No ☐
Please specify the cause of infertility, if known: _____

Have you and / or your partner had:

Carrier testing for cystic fibrosis?: Yes ☐ No ☐

Carrier testing for any other genetic disorder?: Yes ☐ No ☐

Blood chromosome testing?: Yes ☐ No ☐

Are you taking the following:

Medications: Yes ☐ No ☐
If yes please list: _____

Recreational Drugs: Yes ☐ No ☐

Alcoholic drinks: Yes ☐ No ☐

Cigarette smoking: Yes ☐ No ☐

Do you have diabetes, PKU (phenylketonuria) or lupus?: Yes ☐ No ☐

Are you considering or have you used:

Egg donor?: Yes ☐ No ☐

Donor sperm?: Yes ☐ No ☐

Preimplantation Genetic Diagnosis (PGD): Yes ☐ No ☐

Preimplantation Genetic Screening (PGS)?: Yes ☐ No ☐

Intracytoplasmic sperm injection (ICSI)?: Yes ☐ No ☐

☐ I have answered these questions to the best of my knowledge.

Patient Signature _____

Date: _____

Permission to Contact Insurance Carrier and Agreement of Financial Responsibility

AUTHORIZATION FOR COASTAL FERTILITY MEDICAL CENTER / REPRODUCTIVE SPECIALTY LABS TO CONTACT MY INSURANCE CARRIER

☐ I authorize Coastal Fertility Medical Center/Reproductive Specialty Labs to inquire on my behalf, regarding information about my benefits and coverage. I also authorize the release of any medical or other information necessary to process my insurance claim(s).

Patient signature _____

Date(Patient): _____

Partner's signature _____

Date(Partner): _____

AGREEMENT OF FINANCIAL RESPONSIBILITY and AUTHORIZATION TO BILL DESIGNATED INSURANCE CARRIER(S)

☐ I authorize Coastal Fertility Medical Center (CFMC) / Reproductive Specialty Labs (RSL) to bill my insurance carrier(s), and I also authorize benefits to be paid directly to CFMC and RSL. If my insurance carrier, for any reason, will not cover a particular treatment, medication, or procedure, either in full or part, I understand, and agree it is my responsibility to remit payment in full, unless prior written arrangements have been made with the CFMC/RSL billing department.

Patient's Signature:_____

Date(Patient): _____

SIGN BELOW ONLY IF YOU DO NOT WANT US TO CONTACT YOUR INSURANCE CARRIER

DO NOT CONTACT INSURANCE CARRIER

I wish to be a cash account. PLEASE DO NOT CONTACT MY INSURANCE CARRIER FOR ANY REASON, unless I request (in writing) for you to do so.

Patient's signature: _____

Date(Patient): _____

Partner's Signature: _____

Date (Partner): _____

Coastal Fertility Medical Center | RSMC

Insurance Verification

Dear Patient: To assist you in understanding your infertility benefits, we ask that you call your insurance company and ask the following questions. This will give you a better understanding of how your insurance may cover your treatment at Coastal Fertility Medical Center.

Does my health plan participate with Lawrence Werlin, M.D. or Coastal Fertility Medical Center?

1. Does my health plan participate with Lawrence Werlin, M.D. or Coastal Fertility Medical Center? (TAX I.D.# 33 0870026)
2. Do I have infertility benefits? If yes, then ask the following questions.
3. Do I have out of network benefits?
4. If you have a POS plan, ask the clerk which tier offers the best infertility coverage.
5. What services are covered for infertility?
    - Consultation
    - Second Opinion?
    - Diagnostic Testing?
    - Diagnostic or Corrective Surgery?
    - Medications:
        - Oral:
        - Self Injectable:
    - Treatment:
        - IUI (artificial insemination) IVF (in-vitro fertilization)
    - Do I have any limits on number of attempts?
    - Do I have any monetary limit?
    - What is my deductible?
    - Do I have an out of pocket maximum?
    - Do I need pre-certification?

Download Questions

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Email Consent

Patient Name: _____

Patient E-mail Address: _____

RISK OF USING EMAIL

Coastal Fertility Medical Center (CFMC) offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an email.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect e-mails transmitted through their systems,
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court

CONDITION FOR THE USE OF E-MAIL

CFMC will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, CFMC cannot guarantee the security and confidentiality of e-mail communication and will not e liable for improper disclosure of confidential information that is not caused by Provider’s intentional misconduct. Thus, patients must provude written consent, except as authorized or required by law.

Consent to the use of e-mail for patient information. Consent to the use of E-mail includes agreement with the following conditions:

- All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals, authorized to access the medical record, such As staff and billing personnel, will have access to those e-mails.
- Your Provider may forward e-mails internally to CFMC staff and agents as necessary for diagnosis, treatment, reimbursement, health care operations, and other handling .Your Provider will not, however forward e-mails to independent third parties without the patient' s prior written Consent, except as authorized or required by law.
- Although CFMC staff will endeavor to read and respond Promptly to an e-mail from the patient, we cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus the patient shall not use e-mail for medical emergencies or other time-sensitive matters.
- If the patients e-mail requires or invites a response from Provider and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- The patient should not use e-mail for communicationregarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental Health, developmental disability, substance abuse.
- The patient is responsible for informing your provider of any type of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above
- The patient is responsible for protecting his/her pass word or other means of access to e-mail. CFMC is not liable for breaches of confidentiality caused by the patient or any third party.
- CFMC Providers shall not engage in e-mail communication that is unlawful, such as unlawful practicing medicine

across state lines.

- It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS

To communicate by e-mail, the patient shall:

- Limit or avoid use of his/her employer’s computer.
- Inform CFMC of changes in his/her e-mail address.
- Put the patient's name in the body if the e-mail.
- Include the category of the communication in the e.mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear and that all relevant information is provided before sending to your Provider.
- Inform your Provider that the patient received an email from your Provider.
- Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by e-mail or written communication to your Provider.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between CFMC staff and me, and consent to the conditions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient signature: _____

Date(Patient): _____

Thank you for taking the time to make this all. When you come in for your consultation, you will meet with a financial advisor who will compare notes with your research and the verification that took place in our office. If three are any discrepancies, another call will be made by our staff to give us an accurate picture of what your insurance covers.

Privacy Notice

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND ACKNOWLEDGMENT OF MEDICAL BOARD OF CALIFORNIA NOTICE TO CONSUMERS

I acknowledge that I have read the Privacy Notice
Patient or Personal Representative: _____

Date: _____

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

Patient's signature: _____

Date(Patient): _____

Partner's signature: _____

Date(Partner): _____

☐ I HAVE READ AND AGREE TO THE FINANCIAL POLICIES ENCLOSED