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 ☐		
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:** _____

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Infertility History

Has a Penis

First Name:	**Middle Initial:**	**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:

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 ☐ Quit ☐
How many/day?: **How many years?:**
If Quit, When:

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 ☐
please describe:

Do you exercise?: Yes ☐ No ☐
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

Other: _____

Any medications? : _____

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

Have you had a vasectomy reversal?: 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: _____

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

You allergic to any medications?: Yes ☐ No ☐
Date: _____

SPOUSE PATIENT'S SIGNATURE _____

Date(Patient): _____

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

PARTNER MEDICAL HISTORY AND INFORMATION

My Partner has a Uterus

Partner

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 ☐
If yes, please explain: _____

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 explain: _____

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?: _____

Dates of the 1st day of your last 2 menstrual periods: _____

Age when you had your first period: _____

How many periods do you have per year?: _____

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

Do you need medication to bring on a period?: Yes ☐ No ☐
If yes: _____

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

Sexual History

How many times do you have intercourse per week?: _____

Have you used over-the-counter ovulation kits to time intercourse: _____

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

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 ☐
Please list and describe reactions: _____

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 ☐
Please list: _____

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

Social History

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

Do you smoke cigarettes? : Yes ☐ No ☐
How many/day?: _____ **Quit - when?:** _____

Do you drink alcohol?: Yes ☐ No ☐

Surgical History

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

Year	Type of surgery in chronological
_____	_____

Did you have any anesthesia problems?: Yes ☐ No ☐
Describe: _____

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
☐ Ringing ears
☐ 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
  ☐ 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

  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 : _____

Disorders in Your Family

Medical Disorders	Yes/No/Don't Know	If yes, please list relationship to you
Breast cancer		
Ovarian cancer		
Other cancer		

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
☐	Thyroid test		
☐	Ovulation test		
☐	Day 3 blood test for FSH level		
☐	Hysterosalpingogram (HSG)		
☐	Laparoscopy		
☐	Hysteroscopy surgery		

☐	Progesterone blood test		

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:

List

Dates (MM/YY to MM/YY)	Outcome

# of eggs	# of embryos transferred	# frozen

☐ **Frozen embryo transfers**

No. of cycles:

List

Dates (MM/YY to MM/YY)	Outcome

# of eggs	# of embryos transferred	# frozen

Cancelledin vitro fertilization attempt(s): # of cycles : _____

Any other prior treatment (describe): _____

Additional Information/Complications: _____

PARTNER'S SIGNATURE _____

Date (Partner): _____

Physician Notes (for office use only): _____

Coastal Fertility Medical Center | RSMC

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.

Coastal Fertility Medical Center | RSMC

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

Coastal Fertility Medical Center | RSMC

Credit Card Authorization Agreement Form

I/We,

Name: _____

Other Name: _____

authorize Coastal Fertility Medical Center to use the below credit card for services rendered. I understand that all fees for services rendered need to be paid at the time of the visit or prior to the service performed. In the event that

Account/Chart Number (If known): _____

Card holder's name as it appears on card: _____

Type of Card: Visa ☐ MasterCard ☐ AMEX ☐ Discover ☐

Credit Card Number: _____

Security Code: _____

Expiration Date: _____

Billing Address: _____

STORAGE PATIENTS

☐ PLEASE USE THIS CREDIT CARD FOR MY ANNUAL STORAGE BILLING.*if this is checked we will automatically charge your credit card for your annual storage fees*

OTHER ACCOUNT BALANCES

☐ PLEASE USE THIS CREDIT CARD FOR MY ANNUAL STORAGE BILLING.

if this is checked we will automatically charge your credit card for your annual storage fees

Amount: _____

☐ PLEASE CHECK HERE IF YOU WISH TO KEEP YOUR CARD ON FILE FOR FUTURE PAYMENTS

Special Instructions (i.e. split payment?): _____

Card Holder's Signature: _____

Date: _____

Print Name: _____

Patient Signature (If different from Card Holder): _____

Date: _____

***Please note: All credit card information is kept confidential. Every effort will be used to keep this and all confidential information secure. Thank you.additional services/fees are required, Coastal Fertility Medical Center will notify us of any charges due prior to charging our card.**