

# Patient Forms

## Contact Information

### Patient

|                                      |  |  |  |
|--------------------------------------|--|--|--|
| <b>First Name:</b> _____             | <b>Last Name:</b> _____  | <b>Middle Initial:</b> _____             | <b>Marital Status:</b> _____   |
| <b>Best Ph # To Reach You:</b> _____ | <b>OK to leave a message?:</b><br>Yes <input type="checkbox"/> No <input type="checkbox"/> | <b>2nd Best Ph # To Reach You:</b> _____ | <b>OK to leave a message?:</b><br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <b>Date Of Birth:</b> _____          | <b>E-mail:</b> _____   | <b>Age:</b> _____                        | <b>Address:</b> _____  |
| <b>City:</b> _____                   | <b>State:</b> _____  | <b>Zip Code:</b> _____                   | <b>DRIVER'S LIC:</b> _____   |
| <b>State:</b> _____                  | <b>Occupation:</b> _____   | <b>Work Hours:</b> _____                 | <b>Employer:</b> _____   |
| <b>City:</b> _____                   | <b>State:</b> _____  | <b>Zip Code:</b> _____                   |  |

**Do You have Partner ?:** Yes ☐ No ☐

### Referral information

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

### Insurance information

#### Patient

|  |                                  |                              |
|--|----------------------------------|------------------------------|
| <b>PRIMARY INS:</b> _____  | <b>Insured's Name:</b> _____     | <b>Insurance ID:</b> _____   |
| <b>Type :</b> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> EPO <input type="checkbox"/> OTHER <input type="checkbox"/>   |                                  |                              |
| <b>CLAIMS ADDR:</b> _____  | <b>City:</b> _____               | <b>State:</b> _____          |
| <b>Zip Code:</b> _____   | <b>Phone:</b> _____              |                              |
| <b>Do You have Partner?:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>  | <b>PRIMARY INS:</b> if Yes _____ |                              |
| <b>Emergency contact person (not living with you):</b><br>_____  | <b>Relationship:</b> _____       | <b>Insured's Name:</b> _____ |
| <b>Insured:</b> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> EPO <input type="checkbox"/> OTHER <input type="checkbox"/> |                                  |                              |
| <b>CLAIMS ADDR:</b> _____  | <b>City:</b> _____               | <b>State:</b> _____          |
| <b>Zip Code:</b> _____   | <b>Phone:</b> _____              |                              |

**Do you have document to upload?:** Yes ☐ No ☐

**Upload Front Insurance:** \_\_\_\_\_

**Upload Back Insurance:** \_\_\_\_\_

|                                      |             |                            |                    |
|--------------------------------------|-------------|----------------------------|--------------------|
| <b>Patient's signature:</b><br>_____ | <b>Date</b> | <b>Partner's Signature</b> | <b>Date:</b> _____ |
|--------------------------------------|-------------|----------------------------|--------------------|

# Infertility History

Has a Uterus

|                      |                        |                            |               |
|----------------------|------------------------|----------------------------|---------------|
| 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: \_\_\_\_\_

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:** \_\_\_\_\_

**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:** \_\_\_\_\_

**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 ☐

**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 treatment
- ☐ 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:** \_\_\_\_\_

## 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 ☐

## 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  
**please describe:** asdas

## 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

☐ 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 cancer
- ☐ Burn injury

- ☐ 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 : \_\_\_\_\_

## 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 |
|--------------------------|--------------------------------|-------|---------|
| <input type="checkbox"/> | Thyroid test                   | _____ | _____   |
| <input type="checkbox"/> | Ovulation test                 | _____ | _____   |
| <input type="checkbox"/> | Day 3 blood test for FSH level | _____ | _____   |
| <input type="checkbox"/> | Hysterosalpingogram (HSG)      | _____ | _____   |
| <input type="checkbox"/> | Laparoscopy                    | _____ | _____   |
| <input type="checkbox"/> | Hysteroscopy surgery           | _____ | _____   |
| <input type="checkbox"/> | Progesterone blood test        | _____ | _____   |
| <input type="checkbox"/> | Prolactin blood test kit       | _____ | _____   |
| <input type="checkbox"/> | None of these                  |       |         |

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:** \_\_\_\_\_

**Do you have a spouse/partner? :** Yes ☐ No ☐ other ☐

**Please Specify:**\_\_\_\_\_

# Email Consent

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**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 be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must provide 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 patient's 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 communication regarding 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 password 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 of 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 there are any discrepancies, another call will be made by our staff to give us an accurate picture of what your insurance covers.

# Privacy Notice

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## 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):** \_\_\_\_\_

☐ I HAVE READ AND AGREE TO THE FINANCIAL POLICIES ENCLOSED

# Credit Card Authorization Agreement Form

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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.**