Thank you for your interest in the PGD based gender selection program conducted by the Fertility Institutes in Los Angeles.

Our program is a world leader in providing those interested in achieving a pregnancy of a desired gender (sex) a near 100% (99.99%) chance of assuring that a pregnancy achieved using our PGD technology will result in the pre-selected gender outcome.

The attached documents have been compiled and provided in advance to allow you time to complete the necessary paperwork prior to your visit to our facility. Please fill out all of the forms to the best of your ability and bring the completed forms to your appointment. This will allow us the opportunity to assure that the time provided for you with us can be spent introducing you to all of the important details of our program. Feel free to call should you have any questions or concerns filling out the paperwork.

The Fertility Institutes conduct the world’s largest and busiest PGD based sex selection program. The physicians, scientists and technical staff at the Center have appeared on over 60 national and international news programs, detailing the success with sex selection at The Fertility Institutes. Services have been provided to people from over 40 nations on every continent.

In addition to providing gender related genetic testing of embryos, we offer comprehensive preimplantation genetic screening for over 200 different genetic diseases. Through our affiliation with the world’s leading genetic diagnosis centers, we offer the ability to screen embryos for a wide array of genetic disorders that may be associated with either known or suspected genetic disease, recurrent miscarriage, unexplained infertility or failed prior in vitro fertilization attempts.

Our andrology (male reproduction) center has the ability to prescreen the sex ratio (number of “boy” producing sperm and number of “girl” producing sperm) found in the semen of a father to be. By carefully analyzing these ratios, we are able to offer interested individuals a picture of their chances of achieving a pregnancy of one gender or the other.

Thank you once again for your interest in our program and rest assured that you are in contact with a world leader in the provision of reproductive options and family balancing.
Patient Registration

Name:_________________________ DOB:_______ Age:_____ Sex: □ F   □ M

Maiden Name: ___________________ Email Address:________________________

Address:_________________________ City:__________ State:_______ Zip:_______

Home Phone:______________________ Cell:____________________ Fax:______________________

SS#________________ Driver’s License #:__________________________

Employer:_________________________ Occupation:________________________

Work Address:_____________________ City:__________ State:_______ Zip:_______

Work Phone:______________________ Emergency Contact:____________ Phone:____________________

Spouse or Guarantor:_________________________ Relationship:____________________

Age:__________ Sex: □ F   □ M  Driver’s License#:________________________

Address:_________________________ SS#________________ DOB:____________________

(if not same as above)

Home Phone:______________________ Cell:____________________ Fax:______________________

Employer:_________________________ Occupation:________________________

Work Address:_____________________ City:__________ State:_______ Zip:_______

Insurance Company:_________________________ Subscriber #:________________________

Address:_________________________ City:__________ State:_______ Zip:_______

Phone:_________________________ Adjuster:________________________

Policy ID’s (Group, Certif., Policy #’s):________________________

Credit and Collections Policy

Payment for all services rendered is expected at the time of service. You will be issued a receipt at the time of payment that contains all of the information required by insurance companies for consideration of reimbursement. VISA, MASTERCARD and AMERICAN EXPRESS credit cards may be used for payment if so desired. Bank transfers are also accepted. Overdue accounts are subject to interest charges at 60 days. At 90 days, overdue accounts may be referred to a third party collection agency. These agencies are nationwide and international credit collection services. Once referred for collection, we forfeit the ability to further manage or discuss your account with you. Because of this, you are urged to bring any billing disputes to our attention as soon as noted. Delinquent account reports WILL adversely impact the credit ratings of affected individuals.

Credit Inquiry Authorization:________________________

(required signature)

Referred by:_________________________ Address:________________________

Phone #:_________________________ Medical Problem:________________________
Date of last physical examination: ________

Please list any symptoms that may be bothering you (if any):

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

Fertility Intake Form; No Symptoms □

If Living: Age ________ Health ________

If Deceased: Age at death ________ Cause ________

Has any blood relative ever had: Cancer No Yes

Please circle: No or Yes Who

Cancer
Tuberculosis No Yes
Diabetes No Yes
Heart Trouble No Yes
High Blood Pressure No Yes
Stroke No Yes
Epilepsy No Yes
Insanity No Yes
Suicide No Yes

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so.

PERSONAL HISTORY

ILLNESSES: Have you ever had the following:

Please encircle all answers: No Yes

Measles ________
German Measles ________
Mumps ________
Chicken Pox ________
Whooping Cough ________
Scarlet Fever or Scarletina ________
Diphtheria ________
Smallpox ________
Pneumonia ________
Influenza ________
Pleurisy ________
Rheumatic Fever or Heart Disease ________
Arthritis or Rheumatism ________
Any bone or joint disease ________
Neuritis or Neuralgia ________
Bursitis, Sciatica or Lumbago ________
Polio or Meningitis ________
Nephritis ________
Gonorrhea or Syphilis ________
Gallbladder Disease ________
Anemia ________
Jaundice ________
Bladder Disease ________
Epilepsy ________
Migraine Headaches ________
Tuberculosis ________
Diabetes ________
Cancer ________

Nursing: Has ever had:

INJURIES: Have you had any:

Broken or cracked bones ________
Sprains ________
Lacerations ________
Dislocations ________
Concussion or head injury ________
Ever been knocked unconscious ________

Weight: Now ________ One Year Ago ________

Maximum ________ When ________

TRANSFUSIONS: Have you ever had:

Blood or plasma transfusion ________ No Yes

This form is a general health history. There may be a separate history form attached with more detailed questions related to your specific condition(s). Please fill out all history forms to the best of your ability.

P.I. Please do not write in this space

TO THE BEST OF YOUR ABILITY

To your specific condition(s). Please fill out all history forms

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so.
DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

- Frequent or severe headaches ____________ No Yes
- Fainting spells___________________________ No Yes
- Dizziness on change of position__________ No Yes
- Unconsciousness__________________________ No Yes
- Blurred vision___________________________ No Yes
- Double vision____________________________ No Yes
- Spots before eyes________________________ No Yes
- Infected eyes_____________________________ No Yes
- Pain behind eyes__________________________ No Yes
- Any change in vision______________________ No Yes
- Do you wear glasses_______________________ No Yes
- When were they last checked__________________
- Nausea or vomiting________________________ Yes
- Relieved by food or medication_______________ Yes
- Palpitations or fluttering of heart____________ Yes
- Walking several blocks____________________ No
- Night sweats______________________________ No
- Recurrent nose bleeds______________________ No
- Recurrent head colds_______________________ No
- Sinus trouble______________________________ No
- Hay fever_______________________________ No
- Strange persistent odor____________________ No
- Strange taste or loss in taste________________ No
- Persistent hoarseness_______________________ No
- Difficulty swallowing______________________ No
- Enlarged glands____________________________ No
- Recurrent sore throats______________________ No
- Recurrent sores in mouth____________________ No
- Soreness or bleeding of gums on brushing____ No
- Chest pain_______________________________ No
- Angina pectoris____________________________ No
- Coughed up blood__________________________ No
- Pain in arm(s)____________________________ No
- Night sweats______________________________ No
- Chronic or frequent cough___________________ No
- Chronic or frequent cough on laying down__ No
- How many bed pillows do you use?________
- Shortness of breath on:
  - Walking several blocks____________________ No
  - One flight of stairs_______________________ No
  - On laying down__________________________ No
- Purple lips or fingers_______________________ No
- Palpitations or fluttering of heart___________ No
- High blood pressure_______________________ No
- Swelling of hands, feet or ankles____________ No
  - At what time of day______________________
- Leg cramps on waking or at night___________ No
- Enlarged veins in leg_______________________ No
- Recurrent stomach pain____________________ No
- Belching or heartburn______________________ No
- Relieved by food or medication_______________ No
- Appetite — Good ☐ Fair ☐ Poor ☐
- Nausea or vomiting________________________ No
- Vomited blood____________________________ No
- Avoid some foods__________________________ No
- What kinds_______________________________
- Avoid spices______________________________ No
- Abdominal cramping________________________ No
- Color of bowel movement___________________
- Any blood in BM___________________________ No
- Rectal pain with bowel movement____________ No
- Discharge from penis_______________________ No
- Recurrent back pains_______________________ No
- Backaches_______________________________ No
- Joint pains______________________________ No
- Swelling of any joints______________________ No
- Redness or heat of any joint________________ No
- Tingling or weakness of hands or feet______ No
- Trembling of any extremity__________________ No
- Growth in neck or throat____________________ No
- Hot flashes_______________________________ No
- Tiredness without apparent reason___________ No
- Brittleness of nails________________________ No
- Dryness of skin____________________________ No
- Easy bruising_____________________________ No
- Inability to stand heat______________________ No
- Inability to stand cold______________________ No
- Change in hair texture_____________________ No
- Change in skin texture_____________________ No
- Any skin rash____________________________ No
- X-RAYS: Have you ever had x-rays of:
  - Chest_______________________________ No
- Stomach or colon__________________________ No
- Gall bladder____________________________ No
- Extremities______________________________ No
- Back______________________________ No
- Teeth______________________________ No
- Other______________________________ No
- EKG: Have you ever had an electrocardiogram___ No
- IMMUNIZATIONS: Have you had:
  - Smallpox vaccination within last 7 years____ No
  - Tetanus shots (not antitoxin which last only 2 weeks)____ No
  - Polio shots within last 2 years__________ No
- DRUGS:
  - Laxatives:  never occurrences daily
  - Vitamins:  never occurrences daily
  - Sedatives:  never occurrences daily
  - Tranquilizers:  never occurrences daily
  - Sleeping pills, etc:  never occurrences daily
  - Aspirin, etc:  never occurrences daily
  - Cortisone, ACTH:  never occurrences daily
  - Thyroid meds:  never occurrences daily
  - Appetite suppressants:never occurrences daily
  - Sleeping pills, etc:  never occurrences daily
  - Cortisone, ACTH:  never occurrences daily
  - Thyroid meds:  never occurrences daily
- EKG: Have you ever had an electrocardiogram___ No
- IMMUNIZATIONS: Have you had:
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  - Sleeping pills, etc:  never occurrences daily
  - Aspirin, etc:  never occurrences daily
  - Cortisone, ACTH:  never occurrences daily
  - Thyroid meds:  never occurrences daily
  - Appetite suppressants:never occurrences daily
  - Sleeping pills, etc:  never occurrences daily
  - Cortisone, ACTH:  never occurrences daily
  - Thyroid meds:  never occurrences daily
- Have you ever been treated for drug habits____ No
- Have you ever taken insulin or tablets for diabetes____ No
- Have you ever taken insulin or tablets for diabetes____ No
- SEX: Entirely satisfactory__________ No
- WOMEN ONLY — MENSTRUAL HISTORY
  - Age at onset__________________________
  - Regular? Yes ☐ No ☐ Varies ☐
  - Cycle______________________________ days (from start to finish)
  - Flow: Heavy ☐ Medium ☐ Light ☐
  - Number of pads or tampons used per period________
  - Any clots passed_____________________ No
  - Pains or cramps______________________ No
  - Date of last period____________________ No
  - Date of last pelvic exam________________ No
  - Date of last Pap Test___________________
  - Results Pos. ☐ Neg. ☐
  - Any discharge from vagina_______________ No
  - If so, what color_______________________
  - Amount____________________________
  - Any itching of vaginal area_______________ No
  - Do you take birth control pills__________ No
  - How long have you taken them__________
  - Pregnancies:
    - How many children born alive__________
    - How many still births________________
    - How many premature births___________
    - How many Cesarean sections___________
  - How many miscarriages______________
  - Any complications with pregnancy________ No
  - Please describe_______________________
Patient Information Form

Date of scheduled visit: _____/_____/_____  Today’s Date: _____/_____/_____

NAME: _________________________________ SS# : ______-____-______

Date of birth: _____/_____/_____   Age: _______

Your Occupation: __________________________________________________________________________

Email address: ____________________________________________________________________________

Referral Information:

Reason for visit: __________________________________________________________________________

How did you hear about our program? _______________________________________________________________________

Were you referred by another patient?  Y  or  N

OR

Referring doctor’s name: _______________ Phone (_____)_______-_________ Fax (_____)______-_________

Address:____________________________________________________________________________________

(street)      (city)   (state)  (zip)

Is this the physician you see for routine Gynecologic care? (annual Pap smears, etc)  Y  or  N

If no, who is your regular gynecologist? ___________________________________________________________

Address: ____________________________________________________________________________________

(street)      (city)   (state)  (zip)

Is there another physician (s) to whom you would like us to send a letter?  Y  or  N

If yes, physician name: ____________________________

Address: ____________________________________________________________________________________

(street)      (city)   (state)  (zip)

Emergency Contact Information:

In case of emergency please contact: ______________________  Relationship: __________________________

Phone: (____)____-_________ Beeper: (____)____-_________ Cell Phone: (____)____-_________

Address:____________________________________________________________________________________

(street)      (city)   (state)  (zip)
MEDICAL INFORMATION

NAME: _________________________________  SS# : _____-____-______

| Years of current marriage (duration of relationship) | ______ |
| Number of marriages | ______ |
| Duration of infertility (months of trying w/o birth control) | ______ |
| Age of first menstrual period | ______ |
| Number of days bleeding during menstrual period | ______ |
| Number of days between menstrual periods | ______ to ______ |
| (From the 1st day of bleeding to the next, 1st day of bleeding) |

<table>
<thead>
<tr>
<th>Circle One</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any symptoms prior to your menses?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you have painful menses (dysmenorrhea)?</td>
<td>Yes</td>
</tr>
<tr>
<td>Is intercourse painful?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you ever used an intrauterine device (IUD)?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you have a history of pelvic infection (PID)?</td>
<td>Yes</td>
</tr>
<tr>
<td>Did you mother take DES during her pregnancy?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you have discharge from your breasts (galactorrhea)?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you feel you experience excessive hair growth (hirsutism)?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
**PREGNANCY DATA**: Please list all pregnancies

<table>
<thead>
<tr>
<th>#</th>
<th>Date Pregnancy Delivered/Ended</th>
<th>Pregnancy Outcome</th>
<th>Infertility Treatment? E.g., clomid, fertinex, IUI, IVF</th>
<th># Months required to conceive</th>
<th>Sex M/F</th>
<th>Conceived with current partner?</th>
<th>Comments (weight, complications, etc.)</th>
</tr>
</thead>
<tbody>
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*Additional room at the end of the form*

**Previous Testing**: list any previous fertility testing, including dates and results if known.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

**Previous Treatment**: list any previous fertility treatments, including dates and types.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Have you ever had a **hysterosalpinogram** (hysterogram, HSG)? Indicate date and test results.

________________________________________________________________________________________
________________________________________________________________________________________
**IVF History:** Number of previous IVF/GIFT/ZIFT/TET cycles: ______. Please list information regarding any of these prior cycles. Please be as detailed as possible, including dates, locations, dosages of medication and outcomes of cycles.

<table>
<thead>
<tr>
<th>#</th>
<th>Date</th>
<th>Location of program</th>
<th>Medication dosage</th>
<th>Peak estradiol</th>
<th># of eggs</th>
<th># GIFT’d</th>
<th># Fertilized</th>
<th>Fertilization Method</th>
<th># Transferred</th>
<th>Pregnancy</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

*(Additional room at the end of the form)*

**Previous Surgery:** Please list all surgeries, related to infertility or not

<table>
<thead>
<tr>
<th>Date</th>
<th>Location of procedure</th>
<th>Procedure</th>
<th>Findings</th>
<th>Surgeon</th>
<th>Asst.</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

*(Additional room at the end of the form)*

**Additional Information**

- **Circle One**
  - Rubella Immunity...Date Tested __/__/__ Immune Non-Immune  Pap... Date tested __/__/__ Normal? Yes No
  - Mycoplasma...Date tested __/__/__ Positive Negative  Blood Type...  ____________
  - Chlamydia...Date tested __/__/__ Positive Negative  Mammogram...Date tested __/__/__

- **Circle One**
  - Normal? Yes No

4
**Medical History:** Do you have any medical problems unrelated to your infertility? Please check all that apply:

- Diabetes
- High Blood Pressure
- Overactive/Underactive Thyroid
- Epilepsy (seizures)
- Frequent urinary tract infections
- Kidney Disease
- Illicit drug use
- Deep Vein Thrombosis
- Anemia
- Hepatitis
- Rubella (German measles)
- Sexually Transmitted Diseases (syphilis, gonorrhea, herpes, genital warts)
- Asthma

Please explain: 

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

**Family History:** Do any diseases run in your family? Do any of your relatives suffer from a major illness? Please indicate the nature of the illness and family member.

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

<table>
<thead>
<tr>
<th>Circle One</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does anyone in your family have a history of breast cancer?</td>
<td>Yes</td>
</tr>
<tr>
<td>Does anyone in your family have a history of ovarian cancer?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you have any family history of birth defects?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you have any family history of recurrent pregnancy loss?</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you ever suffered from an eating disorder?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you exercise? How frequently and what type?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you have any allergies to medication?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you smoke cigarettes? <strong>Cigarettes Per day</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>Do you drink alcohol? <strong>Per day</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>Do you take any medications regularly? Please list.</td>
<td>Yes</td>
</tr>
<tr>
<td>Have you been exposed to any toxins?</td>
<td>Yes</td>
</tr>
<tr>
<td>Do you use vaginal lubricant during intercourse?</td>
<td>Yes</td>
</tr>
<tr>
<td>Did you mother have a hysterectomy?</td>
<td>Yes</td>
</tr>
<tr>
<td>How many times a month do you have intercourse?</td>
<td></td>
</tr>
</tbody>
</table>
Have you ever used an ovulation predictor kit? What days of your cycle does it indicate ovulation? ______

How many cups of coffee or caffeinated beverages do you drink each day? ____________________________

Are you on any special diets or nutritional supplements? If yes, please explain _________________________
_________________________________________________________________________________________

Do you take multivitamin supplements? ________________________________________________________

Do you use any herbal remedies? ______________________________________________________________

Do you take any over the counter medication? If yes, please explain _________________________________
_________________________________________________________________________________________

**Genetic Screening**: The following questions will help us determine if you are at increased risk for having a child with a genetic problem and if special screening is indicated.

Do you, or anyone in your family, have a history of: (check all that apply and indicate relationship to you)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relationship to you</th>
<th>Condition</th>
<th>Relationship to you</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thalassemia</td>
<td></td>
<td>Muscular Dystrophy</td>
<td></td>
</tr>
<tr>
<td>Neural Tube defect</td>
<td></td>
<td>Cystic Fibrosis</td>
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<tr>
<td>Down Syndrome</td>
<td></td>
<td>Huntington’s Chorea</td>
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<tr>
<td>Tay Sachs</td>
<td></td>
<td>Mental Retardation</td>
<td></td>
</tr>
<tr>
<td>Hemophilia</td>
<td></td>
<td>Sickle Cell Anemia</td>
<td></td>
</tr>
<tr>
<td>Other inherited/chromosomal/genetic abnormalities</td>
<td></td>
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</tr>
</tbody>
</table>

Please Explain: ___________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

**Ethnic Origin**: This will help us identify risk factors for particular inherited diseases. (Please choose all that apply)

____ White non-Hispanic    ____ White Hispanic    ____ Black non-Hispanic    ____ Black Hispanic
____ Asian or Pacific Islander non-Hispanic    ____ Asian or Pacific Islander Hispanic
____ Native American (American Indian including Aleut and Eskimo)
____ French Canadian    ____ Jewish Background
____ Other: (please explain)_________________________________________________________________
MALE DATA

NAME: ______________________________________________________

LAST                   FIRST   MI

Date of birth: _____/_____/____   Age: ______

SS#: ______-____-______    Marriage #: ______

Your occupation: ________________________________________________

Number of pregnancies conceived with current partner: ______

Number of pregnancies conceived with a previous partner: ______  Please give approximate dates and outcomes of any pregnancies conceived with a previous partner.

Urologist (if any) ____________________________________________

Have you ever had a semen analysis (sperm count) performed? If yes, indicate date and results of most recent tests.

<table>
<thead>
<tr>
<th>DATE</th>
<th>Location of Analysis</th>
<th>Count (Million/ml)</th>
<th>Motility and Grade</th>
<th>Morphology</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Do you have any medical problems unrelated to your fertility? Indicate nature of problem and treatment, including treating physician.

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Have you had any surgery? Indicate date and type of operation.

_________________________________________________________________________________________
_________________________________________________________________________________________

Do you take any medications? Indicate medication and dose.

_________________________________________________________________________________________
_________________________________________________________________________________________

Do you smoke cigarettes? Yes    No    _________________________

Do you drink alcohol? Yes    No    _________________________
Do you use any recreational drugs? Yes  No _________________________

Have you been exposed to any toxins? Yes  No _________________________

Do you have any difficulties with erection? Yes  No _________________________

Do you have any difficulties with ejaculation? Yes  No _________________________

Are your genitals exposed to excessive heat? Yes  No _________________________

Have you had any serious injuries to your genitals? Yes  No _________________________

Have you had any infections of your penis, testicles or prostate? Yes  No _________________________

Is there any history of birth defects in your family? Yes  No _________________________

Do you have any allergies to medications? Yes  No _________________________

Are you on any special diets or nutritional supplements? If yes, please explain: _________________________

Do you take multivitamin supplements? _________________________

Do you use any herbal remedies? _________________________

Do you take any over the counter medication? If yes, please explain _________________________

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<table>
<thead>
<tr>
<th>Relationship to you</th>
<th>Relationship to you</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thalassemia</td>
<td>Muscular Dystrophy</td>
</tr>
<tr>
<td>Neural Tube defect</td>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td>Down Syndrome</td>
<td>Huntington’s Chorea</td>
</tr>
<tr>
<td>Tay Sachs</td>
<td>Mental Retardation</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>Sickle Cell Anemia</td>
</tr>
<tr>
<td>Other inherited/chromosomal/genetic abnormalities</td>
<td>_________________________</td>
</tr>
</tbody>
</table>

Please Explain: ___________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________
**Ethnic Origin**: This will help us identify risk factors for particular inherited diseases. (Please choose all that apply)

____ White non-Hispanic     ____ White Hispanic     ____ Black non-Hispanic     ____ Black Hispanic
____ Asian or Pacific Islander non-Hispanic     ____ Asian or Pacific Islander Hispanic
____ Native American (American Indian including Aleut and Eskimo)
____ French Canadian     ____ Jewish Background
____ Other, please explain _________________________________________________________________
Sex Selection Screening History; FEMALE

General Health
Do you exercise at least 3 times per week? ☐ N ☑ Y
Do you drink 64 ounces of water per day? ☐ N ☑ Y
Do you drink caffeinated beverages? ☐ N ☑ Y
Do you use tobacco (if so, how much per day? How many years?) ☐ N ☑ Y: _______ cigarettes/day ________ years
Do you consume alcohol? ☐ N ☑ Y [drinks/wk]
Have you ever dealt with depression? ☐ N ☑ Y
Have you ever been abused? ☐ N ☑ Y
Using the list on the right, please circle any medical conditions that run in your family:

Menstrual – Gyn History
Date of first day of your last menses?
Are your menstrual periods regular?
Do you have heavy bleeding with your menses?
Have you ever been advised you may have (circle): [uterine fibroids or scarring][endometrial polyps][a tight or weak cervix]

Pregnancies
How many pregnancies have you had?
How many children have you delivered: _____ girls: _____ boys: ___________
How old are your children now: _______ _______ _______ _______

What type of deliveries have you had: [Vaginal] [Cesarean]
Were any of your pregnancies complicated?
Were any of your deliveries complicated?
(please circle any complications at right)
Have you had any abortions?
Have you had any miscarriages?
Have you ever been told NOT to become pregnant again? ☐ YES ☐ NO
If yes, REASON: _________________________________________________________________

Contraception (Birth Control)
What type of birth control are you using now?
Very Effective Birth Control Methods:
Somewhat Effective Birth Control Methods:
Not Very Effective Birth Control Methods:

Gender Balance In the Family
Of all of your brothers’ and sisters’ children, total number of: BOYS _______ GIRLS _______
Of all of your partner’s brothers’ and sisters’ children, total number of: BOYS _______ GIRLS _______
Primary reason you are considering sex selection: _______
Is there ANY male child anywhere in the family with the SAME LAST NAME as your partner? ☐ YES ☐ NO
Is this important to you? ☐ YES ☐ NO

Sexually Transmitted Disease
Have you ever had a sexually transmitted disease? [Trichomonas] [Genital warts] [Genital Herpes] [HPV]
Have you ever had Pelvic Inflammatory Disease? [Chlamydia] [Gonorrhea] [Syphilis][Hepatitis A □B □C] [HIV]

Pap Smear
Have you ever had an abnormal Pap Smear? ☐ N ☑ Y
Have you had a Colposcopy procedure? ☐ N ☑ Y [Biopsy] [Freezing] [LEEP] [CONE]

Breast Exam
Have you ever had an abnormal breast exam? ☐ N ☑ Y
Have you had an abnormal Mammogram? ☐ N ☑ Y
What abnormality was found?
Do you do your own self breast exams each month? ☐ N ☑ Y
# FEMALE GENETIC SCREENING

**Name:** __________________________________________ **Age:** __________

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<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>1. Will you be 35 years or older when you have children?</td>
<td></td>
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<tr>
<td>2. Have you or your partner or anyone in your families ever had:</td>
<td></td>
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<tr>
<td></td>
<td>A. DOWN’S SYNDROM (MONGOLISM)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. SPINA BIFIDA OR MENINGOMYEOLOCELE?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. HEMOPHILIA?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. MUSCULAR DYSTROPHY?</td>
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</tr>
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<td></td>
<td>E. CYSTIC FIBROSIS?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F. ANENCEPHALY-HYDROCEPHALY?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G. STILLBORN CHILD?</td>
<td></td>
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<tr>
<td></td>
<td>H. MENTAL RETARDATION?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I. SICKLE-CELL TRAIT/ANEMIA?</td>
<td></td>
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<tr>
<td></td>
<td>J. ARE YOU OR YOUR PARTNER JEWISH?</td>
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<tr>
<td></td>
<td>If yes, have you been screened for Tay-Sachs?</td>
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If you have any specific concerns about genetic screening, please list them here: ____________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the doctor.

- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance
We may accept assignment of insurance benefits after your second visit if you can provide us a letter from your insurer indicating that you are fully covered for the planned treatment with a dollar amount satisfactory to cover your total estimated bill. In the absence of such a letter, we do require 100% of the bill to be paid at time of service. Any unpaid balance on an account is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do conditionally accept assignment of benefits, we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for automatically transferred to your credit card or the extended payment plan. Please be aware that some and perhaps all of the services provided may be non-covered services or considered unreasonable and unnecessary under some medical insurance plans.

Regarding insurance plans where we are participating providers, all pre-authorizations, co-pays and deductibles are due prior to treatment. Should a co-pay or deductible fail to be collected, the balance due will be billed to your credit card account. If services are provided without prior receipt by us of pre-authorization, the charges for such services are due at the time of services rendered. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

Missed Appointments
Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

*I have read the Financial Policy. I understand and agree to this Financial Policy.

X ______________________ X ____________________
Signature of Patient    Signature of Patient (spouse)    Date
PAYMENT DEFINITION, EXPLANATION AND POLICY STATEMENT
FOR ASSISTED REPRODUCTIVE TECHNOLOGY (ART)
PROCEDURES (IVF, ICSI, GIFT, MESA, TET, PGD)

Over the past several years’ major advances in terms of increased pregnancy rates with the
assisted reproductive technologies have been obtained by modifying and enhancing the
techniques involved in the performances of these procedures.

At many centers, including our own, substantial gains in the achievement of pregnancy have been
realized by customizing for each individual couple the many different chemical and biological
preparations that are used in their ART procedure. This custom manufacturing and formulation
process helps assure that the eggs and sperm obtained from each couple for use will be cultured in
an environment customized specifically toward the needs of that couple. This has been repeatedly
shown to optimize the chances of a successful outcome.

The laboratory procedures involved in this customization process are lengthy and detailed.
Because there can be tremendous variability in the length of time required to adequately prepare
for each situation, our policy is to order the laboratory to begin preparatory work for a
planned cycle upon receipt of initial ART payment from patients electing to undertake a
procedure. The formulations prepared for you can be stored for a limited time; however, they
cannot be used for anyone else.

It is important to understand that initial payments for ART procedures will be applied to work and
procedures carried out on your behalf by the laboratory and clinical teams involved in your care
long before your actual treatment cycle begins. This work takes place “behind the scenes.”
Although you may not see or realize the extent of the effort on your behalf, a great deal of the
labor that has lead to our impressive success rates occurs prior to the start of your actual
“clinical” (office visits, ultrasounds, etc.) treatment. Your initial payments to us will be used to
pay for these procedures.

The initial laboratory work carried out on your behalf is mandatory for participation in our
program. Payments of such fees in advance will assure that the laboratory will be ready for your
cycle at any time after the setup is complete. Should you elect to postpone or cancel a planned
cycle at any time after payment for the initial setup work, there will be no subsequent recharge
for another setup at a later time, however there will not be made available any refund for work
already completed on your behalf. It is important to understand that the initial cycle payments
will result in mandatory laboratory setup fees, which approximate 25%-50% of your total cycle
costs. These fees must be considered non-refundable.

*Our signature below indicate that we have read and have had explained to our satisfaction the
above policy related to payment and partial payment for ART cycles performed by Jeffrey
Steinberg, MD, Incorporated including the clinical and laboratory staff.

X____________________________ X_________________________       ____________
Signature of Patient       Signature of Patient (spouse)    Date
PATIENT AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS

Re: (Patient) __________________________________________

Release of Information:
The undersigned, whether she/he signs as agent or patient, hereby authorizes Jeffrey M. Steinberg, M.D. to release or disclose any information acquired in the course of examination or treatment of the patient including her/his medical records to any person or entity which is or may be liable for all or a portion of Jeffrey M. Steinberg, M.D.’s charges including but not limited to insurance companies, health care service plans, or worker’s compensation carriers. A photocopy of this form shall be deemed as valid as the original.

Signature: ____________________________________________
(Patient/Parent/Guardian)

Financial Agreement:
The undersigned agrees, whether she/he signs as agent or as patient, that she/he hereby individually obligates herself/himself to pay to the account of Jeffrey M. Steinberg, M.D. all amounts for professional services not covered or paid by insurance or other third party reimbursement for the same. The undersigned further agrees to immediately, upon receipt of the same, endorse or cause to be endorsed and delivered to Jeffrey M. Steinberg, M.D. all payments made by an insurance company or any other third party for the benefit of the patient of the undersigned as reimbursement for professional services provided by Jeffrey M. Steinberg, M.D.

Assignment of Insurance Benefits:
The undersigned authorizes, whether she/he as agent or as patient direct payment to Jeffrey M. Steinberg, M.D. of any insurance benefits otherwise payable to the undersigned for professional service charges of Jeffrey M. Steinberg, M.D. It is agreed that payment to Jeffrey M. Steinberg, M.D. pursuant to this authorization, by an insurance company shall discharge said insurance of any and all obligation under a policy to the extent of such payment. It is understood by the undersigned that she/he is financially responsible for any and all charges not covered by this assignment.

Attorney’s Fees:
Should this account be referred to an attorney for collection or a litigation brought to enforce its provisions, the undersigned shall pay all reasonable attorney’s fees and collection expenses in addition to all other relief. All delinquent accounts (>60 days from date of service) shall bear interest at the legal rate.

*The undersigned certifies that she/he has read the foregoing, receiving a copy thereof, and is the patient, or duly authorized by the patient as patient’s general agent to execute the above and accept its terms.

Signature: ________________________________ Date: ___________________________
(Patient/Parent/Guardian)