# The Fertility Institutes

**Gender Selection Program**
**16030 Ventura Boulevard, 4th Floor**
**Encino, Ca 91436**
**818-728-4600**
**800-222-2802**

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:_____

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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:_____

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Insurance Company:_____Subscriber #:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Adjuster:_____

Policy ID's (Group, Certif., Policy #'s):_____

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**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:_____

Name _____ Age _____ Single/Married _____ Divorced/Widow(er) _____ Date _____

Occupation _____ All Previous Occupations _____

Birth Place _____ Date of Birth _____ List all states in which you have lived: _____

Education _____ # years High School: _____ # years College: _____ # years Post Grad: _____

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 ☐

**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

| | If Living Age | If Living Health | If Deceased Age at death | If Deceased Cause | Has any blood relative ever had | Please circle No or Yes | Who |
|---|---|---|---|---|---|---|---|
| Father | | | | | Cancer | No Yes | |
| Mother | | | | | Tuberculosis | No Yes | |
| Brother or Sister 1. | | | | | Diabetes | No Yes | |
| 2. | | | | | Heart Trouble | No Yes | |
| 3. | | | | | High Blood Pressure | No Yes | |
| 4. | | | | | Stroke | No Yes | |
| 5. | | | | | Epilepsy | No Yes | |
| Husband or Wife | | | | | Insanity | No Yes | |
| Son or Daughter 1. | | | | | Suicide | No Yes | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |

**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 | No | Yes |
| German Measles | No | Yes |
| Mumps | No | Yes |
| Chicken Pox | No | Yes |
| Whooping Cough | No | Yes |
| Scarlet Fever or Scarlatina | No | Yes |
| Diphtheria | No | Yes |
| Smallpox | No | Yes |
| Pneumonia | No | Yes |
| Influenza | No | Yes |
| Pleurisy | No | Yes |
| Rheumatic Fever or Heart Disease | No | Yes |
| Arthritis or Rheumatism | No | Yes |
| Any bone or joint disease | No | Yes |
| Neuritis or Neuralgia | No | Yes |
| Bursitis, Sciatica or Lumbago | No | Yes |
| Polio or Meningitis | No | Yes |
| Nephritis | No | Yes |
| Gonorrhea or Syphilis | No | Yes |
| Gallbladder Disease | No | Yes |
| Anemia | No | Yes |
| Jaundice | No | Yes |
| Bladder Disease | No | Yes |
| Epilepsy | No | Yes |
| Migraine Headaches | No | Yes |
| Tuberculosis | No | Yes |
| Diabetes | No | Yes |
| Cancer | No | Yes |
| High or low blood pressure | No | Yes |
| Colitis or other bowel disease | No | Yes |
| Hemorrhoids or any rectal disease | No | Yes |
| Nervous Breakdown | No | Yes |
| Food, chemical or drug poisoning | No | Yes |
| Hay Fever or Asthma | No | Yes |
| Hives or Eczema | No | Yes |
| Frequent infections or boils | No | Yes |
| AIDS | No | Yes |
| Any other disease | No | Yes |

ALLERGIES: Are you allergic to

| | | |
|---|---|---|
| Penicillin or Sulfa | No | Yes |
| Aspirin, Codeine or Morphine | No | Yes |
| Mycins or other antibiotics | No | Yes |
| Merthiolate or Mercurochrome | No | Yes |
| Any other drug | No | Yes |
| Any food s | No | Yes |
| Adhesive tape | No | Yes |
| Nail polish or other cosmetics | No | Yes |
| Tetanus antitoxin or serums | No | Yes |

INJURIES: Have you had any

| | | |
|---|---|---|
| Broken or cracked bones | No | Yes |
| Sprains | No | Yes |
| Lacerations | No | Yes |
| Dislocations | No | Yes |
| Concussion or head injury | No | Yes |
| Ever been knocked unconscious | No | Yes |

WEIGHT: Now _____ One Year Ago _____

Maximum _____ When _____

TRANSFUSIONS: Have you ever had

Blood or plasma transfusion _____ No Yes

SURGERY: Have you had

| | | |
|---|---|---|
| Tonsillectomy | No | Yes |
| Appendectomy | No | Yes |
| Other operation | No | Yes |

Type _____ Year _____

Type _____ Year _____

Type _____ Year _____

Do you smoke: No Yes

How many per day _____

Have you ever been advised to have any surgical operation which has not been done? No Yes

Have you been hospitalized for any illness: No Yes

Give Details:

**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
Unconscious spells 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
Earaches No Yes
Discharge from ears No Yes
Ringing in ears No Yes
Decrease in hearing No Yes
Recurrent nose bleeds No Yes
Recurrent head colds No Yes
Sinus trouble No Yes
Hay fever No Yes
Strange persistent odors No Yes
Strange taste or loss in taste No Yes
Persistent hoarseness No Yes
Difficulty swallowing No Yes
Enlarged glands No Yes
Recurrent sore throats No Yes
Recurrent sores in mouth No Yes
Soreness or bleeding of gums on brushing No Yes
Chest pain No Yes
Angina pectoris No Yes
Coughed up blood No Yes
Pain in arm(s) No Yes
Night sweats No Yes
Chronic or frequent cough No Yes
Chronic or frequent cough on laying down No Yes
How many bed pillows do you use?
Shortness of breath on:
Walking several blocks No Yes
One flight of stairs No Yes
On laying down No Yes
Purple lips or fingers No Yes
Palpitations or fluttering of heart No Yes
High blood pressure No Yes
Swelling of hands, feet or ankles No Yes
At what time of day
Leg cramps on walking or at night No Yes
Enlarged veins in leg No Yes
Recurrent stomach pain No Yes
Belching or heartburn No Yes
Relieved by food or medication No Yes
Appetite – Good ☐ Fair ☐ Poor ☐
Nausea or vomiting No Yes
Vomited blood No Yes
Avoid some foods No Yes
What kinds
Avoid spices No Yes
Abdominal cramping No Yes
Color of bowel movement
Any blood in BM No Yes
Rectal pain with bowel movement No Yes

**DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:**

Change in size, shape or texture of BM No Yes
Describe
Pain on urinating No Yes
Difficulty in starting urination No Yes
Do you get up at night to urinate No Yes
How many times
Urinate more than before No Yes
Urinate less than before No Yes
Any blood in urine No Yes
How many times per day do you urinate
Full feeling of bladder, but only small amount of urination No Yes
Los urine on coughing or sneezing No Yes

Discharge from penis No Yes
Recurrent back pains No Yes
Backaches No Yes
Joint pains No Yes
Swelling of any joints No Yes
Redness or heat of any joint No Yes
Tingling or weakness of hands or feet No Yes
Trembling of any extremity No Yes
Growth in neck or throat No Yes
Hot flashes No Yes
Tiredness without apparent reason No Yes
Brittleness of nails No Yes
Dryness of skin No Yes
Easy bruising No Yes
Inability to stand heat No Yes
Inability to stand cold No Yes
Change in hair texture No Yes
Change in skin texture No Yes
Any skin rash No Yes

**X-RAYS: Have you ever had x-rays of**

Chest No Yes
Stomach or colon No Yes
Gall bladder No Yes
Extremities No Yes
Back No Yes
Teeth No Yes
Other No Yes
**EKG: Have you ever had an electrocardiogram** No Yes
**IMMUNIZATIONS: Have you had** No Yes
Smallpox vaccination within last 7 years No Yes
Tetanus shots (not antitoxin which last only 2 weeks) No Yes
Polio shots within last 2 years No Yes

**DRUGS:**
Laxatives: never ☐ occ ☐ freq ☐ daily ☐
Vitamins: never ☐ occ ☐ freq ☐ daily ☐
Sedatives: never ☐ occ ☐ freq ☐ daily ☐
Tranquilizers: never ☐ occ ☐ freq ☐ daily ☐
Sleeping pills, etc: never ☐ occ ☐ freq ☐ daily ☐
Aspirin, etc: never ☐ occ ☐ freq ☐ daily ☐
Cortisone, ACTH: never ☐ occ ☐ freq ☐ daily ☐
Thyroid meds: never ☐ yes, in the past, none now ☐
daily ☐ now on _____ gr./day
Appetite suppressants: never ☐ occ ☐ freq ☐ daily ☐

Have you ever been treated for drug habits No Yes
Have you ever taken insulin or tablets for diabetes No Yes
Have you ever taken hormone tablets or injections No Yes
**SEX:** Entirely satisfactory No Yes

**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 Yes
Pains or cramps No Yes
Date of last period No Yes
Date of last pelvic exam No Yes
Date of last Pap Test
Results Pos. ☐ Neg. ☐
Any discharge from vagina No Yes
If so, what color
Amount
Any itching of vaginal area No Yes
Do you take birth control pills No Yes
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 Yes
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)

| | ***Circle One*** | | **Comments** |
|---|---|---|---|
| Do you have any symptoms prior to your menses? | Yes | No | _____ |
| Do you have painful menses (dysmenorrhea)? | Yes | No | _____ |
| Is intercourse painful? | Yes | No | _____ |
| Have you ever used an intrauterine device (IUD)? | Yes | No | _____ |
| Do you have a history of pelvic infection (PID)? | Yes | No | _____ |
| Did you mother take DES during her pregnancy? | Yes | No | _____ |
| Do you have discharge from your breasts (galactorrhea)? | Yes | No | _____ |
| Do you feel you experience excessive hair growth (hirsutism)? | Yes | No | _____ |

**PREGNANCY DATA**: Please list **all** pregnancies

| # | Date Pregnancy Delivered/ Ended | Pregnancy Outcome | Infertility Treatment? E.g., clomid, fertinex, IUI, IVF | # Months required to conceive | Sex M/F | Conceived with current partner? | Comments (weight, complications, etc.) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

*(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.

| # | Date | Location of program | Medication dosage | Peak estradiol | # of eggs | # GIFT'd | # Fertilized | Fertilization Method | # Transferred | Pregnancy |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

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

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

| Date | Location of procedure | Procedure | Findings | Surgeon | Asst. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

**Additional Information**

| | *Circle One* | | *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 ___/___/___ Normal? Yes No |

**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.
_____
_____
_____

| | ***Circle One*** | | **Comments** |
|---|---|---|---|
| Does anyone in your family have a history of breast cancer? | Yes | No | _____ |
| Does anyone in your family have a history of ovarian cancer? | Yes | No | _____ |
| Do you have any family history of birth defects? | Yes | No | _____ |
| Do you have any family history of recurrent pregnancy loss? | Yes | No | _____ |
| Have you ever suffered from an eating disorder? | Yes | No | _____ |
| Do you exercise? How frequently and what type? | Yes | No | _____ |
| Do you have any **allergies** to medication? | Yes | No | _____ |
| Do you smoke cigarettes? **Cigarettes Per day** _____ | Yes | No | _____ |
| Do you drink alcohol? **Per day** _____ | Yes | No | _____ |
| Do you take any medications regularly? Please list. | Yes | No | _____ |
| Have you been exposed to any toxins? | Yes | No | _____ |
| Do you use vaginal lubricant during intercourse? | Yes | No | _____ |
| Did you mother have a hysterectomy? | Yes | No | Mother's age of menopause_____ |

How many times a month do you have intercourse? _____

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)

| | *Relationship to you* | | *Relationship to you* |
|---|---|---|---|
| ❑Thalassemia | _____ | ❑Muscular Dystrophy | _____ |
| ❑Neural Tube defect | _____ | ❑Cystic Fibrosis | _____ |
| ❑Down Syndrome | _____ | ❑Huntington's Chorea | _____ |
| ❑Tay Sachs | _____ | ❑Mental Retardation | _____ |
| ❑Hemophilia | _____ | ❑Sickle Cell Anemia | _____ |
| ❑Other inherited/chromosomal/genetic abnormalities | _____ | | |

**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.

| DATE | Location of Analysis | Count (Million/ml) | Motility and Grade | Morphology |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

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 _____
_____

**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)

| | *Relationship to you* | | *Relationship to you* |
|---|---|---|---|
| ❑Thalassemia | _____ | ❑Muscular Dystrophy | _____ |
| ❑Neural Tube defect | _____ | ❑Cystic Fibrosis | _____ |
| ❑Down Syndrome | _____ | ❑Huntington's Chorea | _____ |
| ❑Tay Sachs | _____ | ❑Mental Retardation | _____ |
| ❑Hemophilia | _____ | ❑Sickle Cell Anemia | _____ |
| ❑Other inherited/chromosomal/genetic abnormalities | _____ | | |

**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 _____

## ADDITIONAL COMMENTS

# Sex Selection Screening History; FEMALE

## General Health

Do you **exercise** at least 3 times per week? □ N □ Y

Do you eat five **fruits and vegetables** per day? □ N □ Y

Do you **drink** 64 ounces of water per day? □ N □ Y

Are you concerned about your **weight**? □ N □ Y

Do you drink **caffeinated** beverages? □ N □ Y

Do you feel ready for (another) pregnancy? □ 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

Do you use **drugs** for other than prescribed indications? □ N □ Y

Have you ever dealt with **depression**? □ N □ Y

Have you ever tried to hurt yourself (**suicide**)? □ N □ Y

Have you ever been **abused**? □ N □ Y

Do you currently feel **safe**? □ N □ Y

Using the list on the right, please circle any **medical conditions that run in your family**:

[Breast Cancer] [Ovarian Cancer]
[High Blood pressure] [High Cholesterol] [Heart Disease] [Stroke]
[Diabetes] [Thyroid disease]

## Menstrual – Gyn History

Date of first day of your **last menses?**

Is there a chance you could be currently **pregnant**?

Are your **menstrual periods regular?**

How many days between your menstrual periods?

How many days do your menstrual periods last?

Do you have **heavy bleeding** with your menses?

How many pads or tampons are soaked per day?

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**?

[Diabetes] [High blood pressure]

Were any of your **deliveries complicated**?
(please circle any complications at right)

[Forceps or vacuum used] [Heavy bleeding]
[Baby was admitted to ICU]

Have you had any **abortions**?

If so, how many abortions? ___ How many weeks along? ___

Have you had any **miscarriages**?

If so, how many miscarriages? ___ How many weeks along? ___

**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**: [Depo] [Birth control pill] [Norplant] [IUD] [Vasectomy] [Tubal]

**Somewhat Effective Birth Control Methods**: [Diaphragm] [Cervical Cap] [Condom] [Spermicidal gel or foam]

**Not Very Effective Birth Control Methods**: [Rhythm Method] [Withdrawal][No contraceptive]

## Gender Balance In the Family

Of all of <u>your</u> brothers' and sisters' children, total number of: **BOYS** _____ **GIRLS** _____

Of all of your <u>partner's</u> brothers' and sisters' children, total number of: **BOYS** _____ **GIRLS** _____

Primary reason you are considering sex selection: □ Family balancing □ Sex linked disease □ Heir □ Other _____

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** What abnormality was found?

Have you had a **Colposcopy** procedure? □ N □ Y [Biopsy] [Freezing] [LEEP] [CONE]

## Breast Exam

Have you ever had an **abnormal breast exam? □ N** What abnormality was found?

Have you had an abnormal **Mammogram**? □ N □ Y

Do you do your own **self breast exams** each month? □ N □ Y

# FEMALE GENETIC SCREENING


Name:_____ Age:_____

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| | YES | NO |
|---|---|---|
| 1. Will you be 35 years or older when you have children? | ____ | ____ |
| 2. Have you or your partner or anyone in your families ever had: | | |
| A. DOWN'S SYNDROM (MONGOLISM)? | ____ | ____ |
| B. SPINA BIFIDA OR MENINGOMYELOCELE? | ____ | ____ |
| C. HEMOPHILIA? | ____ | ____ |
| D. MUSCULAR DYSTROPHY? | ____ | ____ |
| E. CYSTIC FIBROSIS? | ____ | ____ |
| F. ANENCEPHALY-HYDROCEPHALY? | ____ | ____ |
| G. STILLBORN CHILD? | ____ | ____ |
| H. MENTAL RETARDATION? | ____ | ____ |
| I. SICKLE-CELL TRAIT/ANEMIA? | ____ | ____ |
| J. ARE YOU OR YOUR PARTNER JEWISH? | ____ | ____ |
| If yes, have you been screened for Tay-Sachs? | ____ | ____ |

If you have any specific concerns about genetic screening, please list them here:_____

_____

_____

# OUR FINANCIAL POLICY
## JEFFERY STEINBERG, M.D., INCORPORATED

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 set up work, there will be no subsequent recharge for another set up 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 set up 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 <u>all</u> 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)