Fertility Specialty Care
Registration Information

PATIENT INFORMATION:
Last Name _____
First Name and Initial _____
Address _____
City_____ State_____ Zip Code _____
Home Phone (____) _____ Cell Phone (____)_____
Date of Birth _____
Social Security Number _____
Marital Status ____ Married _____ Single _____ Divorced
Employer _____
Employer Phone Number: (___) _____

SPOUSE OF SIGNIFICANT OTHER INFORMATION:
Last Name _____
First Name and Initial _____
Date of Birth _____ Cell Phone (____)_____
Social Security Number _____
Employer _____
Employer Phone Number (____)_____

EMERGENCY CONTRACT INFORMATION IF DIFFERENT FROM SPOUSE OF SIGNIFICANT OTHER:
Name_____ Relationship_____
Home Phone: (____) _____ Cell Phone (____) _____

INSURANCE INFORMATION:
Insurance Company Name _____
Insurance Company Address _____
City _____State _____ Zip Code _____
Provider Phone Number _____
ID# or Member # _____
Group # _____
Member Name _____
Members Date of Birth _____
Members Social Security Number _____

We ask all patients these questions so we may provide personal care based on your needs. Please look at each section and choose an option that best describes you.

FULL NAME_____

PREFERRED NAME_____

DATE OF BIRTH_____

ETHNICITY
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Choose not to disclose

RACE
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Biracial
- ☐ Two or more races
- ☐ Other_____
- ☐ Choose not to disclose

SEX ASSIGNED AT BIRTH
- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Not recorded on birth certificate
- ☐ Uncertain
- ☐ Unknown
- ☐ Choose not to disclose

LEGAL SEX
- ☐ Female
- ☐ Male
- ☐ X
- ☐ Unknown

GENDER IDENTITY
- ☐ Female
- ☐ Male
- ☐ Transgender Female (Male to Female)
- ☐ Transgender Male (Female to Male)
- ☐ Genderqueer
- ☐ Other
- ☐ Choose not to disclose

PREFERRED PRONOUN
- ☐ HE/HIM/HIS
- ☐ SHE/HER/HERS
- ☐ THEY/THEM/THEIRS
- ☐ CO/COS
- ☐ EN/ENS
- ☐ EY/EM/EIR
- ☐ VE/VIS/VER
- ☐ XIE/HIR/HIRS
- ☐ YO/YOS
- ☐ ZE/HIR/HIRS
- ☐ Other_____

RELIGIOUS PREFERENCE
- ☐ Bahai Faith
- ☐ Baptist
- ☐ Brethren
- ☐ Buddhist
- ☐ Catholic
- ☐ Christian
- ☐ Christian Science
- ☐ Church of Christ
- ☐ Church of God
- ☐ Community Churches
- ☐ Disciples of Christ
- ☐ Episcopalian
- ☐ Ev Church of America
- ☐ Hindu
- ☐ Independent
- ☐ Jehovah's Witness
- ☐ Jewish
- ☐ Latter Day Saints
- ☐ Lutheran
- ☐ Mennonite
- ☐ Methodist
- ☐ Moravian
- ☐ Muslim
- ☐ Native American Indian
- ☐ Nazarene
- ☐ Non-Denominational
- ☐ Orthodox
- ☐ Pagan
- ☐ Pentecostal
- ☐ Presbyterian
- ☐ Protestant
- ☐ Quaker
- ☐ Reformed Church
- ☐ Salvation Army
- ☐ Seventh Day Adventist
- ☐ Shinto
- ☐ Sikh
- ☐ Spiritual Churches
- ☐ Taoist
- ☐ Unitarian Universalist
- ☐ United Church of Christ
- ☐ Unity
- ☐ No Preference
- ☐ Unknown
- ☐ None
- ☐ Other_____
- ☐ Choose not to disclose

Fertility Specialty Care
New Patient Intake Form

PLEASE COMPLETE THIS FORM TO ASSIST US IN PREPARING FOR YOUR VISIT

Date: _____
Name: _____
Date of Birth: _____ Age: _____
Who is your current OB/GYN physician: _____
Who referred you to our office?
____ Physician ____ Internet ____ Friend ____ Insurance Company
If physician, what is the name of the physician? _____
Can we send your referring physician a letter about your visit? YES or NO
What is your marital status: M S W D
If you are not married are you in a mutually monogamous relationship: YES or NO
What is your occupation? _____
What is the best telephone number to reach you? _____
Can we leave instructions and test results on your voice mail? YES or NO
What is the reason for your visit? _____
If you have infertility, how long have you been trying to get pregnant? _____
Date of your last menstrual period (first day of flow)? _____
Age menstrual periods began? _____ Date of last Pap smear? _____
Are your menstrual periods regular when you are not using medicines? YES or NO
Typical number of days in between menstrual periods _____
What is the amount of menstrual bleeding that you have? Light Moderate Heavy
What degree of pain do you have with your menstrual bleeding? Minimal Moderate Severe
Typical number of days your menstrual bleeding lasts? _____
Do you ever spot before your period? YES or NO
Do you use lubricants during intercourse? YES or NO
Do you have pain with intercourse? YES or NO If so, is this position specific? YES or NO
How many times a week or month on average do you have sexual intercourse? _____
Do you ever have pelvic pain? YES or NO If yes, describe location of pain _____
Have you ever had a sexually transmitted disease? YES or NO
If yes, when and which one? _____
Have you had any breast discharge recently? YES or NO
Have you had any concerns about excessive facial or body hair? YES or NO
Have you or your partner traveled to a ZIKA area in the last 6 months? YES or NO

Allergies to medications: (please note the name of the medication and the reaction if known)

_____
_____

Current medications, dose and reason for taking:

_____
_____
_____

Name: _____

List any medical conditions you have and the approximate date they were diagnosed:

_____

_____

List any surgical procedures you have had and the approximate year:

_____

_____

Have you ever had a complication with anesthesia? YES or NO
If so, please explain:

_____

What quantity and how often do you consume alcoholic beverages? _____
Do you smoke? YES or NO If yes, how many packs per day? _____ How many years? _____

Have you ever been pregnant? YES or NO
If yes, please list dates, if infertility treatment was used, present partner involved and outcome:

	Year	Fertility Treatment	Present Partner	Outcome (miscarriage, gestational age, C/S or vaginal)
1.	_____	YES or NO	YES or NO	_____
2.	_____	YES or NO	YES or NO	_____
3.	_____	YES or NO	YES or NO	_____
4.	_____	YES or NO	YES or NO	_____

Do you have a family history of any of the following in blood relatives that are grandparents or closer?
For any yes response, please indicate which relative:

Diabetes: _____ Breast Cancer: _____
Ovarian Cancer: _____ Colon Cancer: _____
Thyroid disease: _____ Pulmonary Disease: _____
Endometriosis: _____ Birth Defects: _____
Kidney Disease: _____ Cardiovascular Disease: _____
Stroke: _____ Hypertension: _____
Blood clots (not associated with illness, injury or old age): _____

Please indicate any treatments for infertility you have had:
Clomid (Clomiphene, Serophene): Number of attempts: _____ Approximate dates: _____
Injectable ovulation cycles (Gonal F, Follistim, Menopur, Bravelle, Repronex):
Number of attempts: _____ Approximate dates: _____
Intrauterine insemination (IUI): Number of attempts: _____ Approximate dates: _____
In vitro fertilization (IVF): Number of attempts: _____ Approximate dates: _____

Name: _____

Please provide us with any records for the following tests or treatments if they were performed outside of Community Health Network (a records release is included in your new patient paperwork):
Hysterosalpingogram (HSG)
Laparoscopy and/or Hysteroscopy with written report and pictures
Hormonal testing:
Anti Mullerian Hormone (AMH)
Follicle Stimulating Hormone (FSH)
Luteinizing Hormone (LH)
Thyroid Stimulating Hormone (TSH)
Prolactin (PRL)
Semen Analysis Reports
Stimulation sheets from ovulation induction or IVF cycles

How quickly are your looking to begin fertility treatment?
ASAP 3-6 months 6 or more months

How are you dealing emotionally with not being able to have a baby?

Has your relationship with your partner been affected by your infertility?

Please use this space to tell us anything you feel is important for us to know about in advance of your visit:

Name: _____

PLEASE ANSWER THE QUESTIONS BELOW IF YOU WILL BE ATTEMPTING CONCEPTION WITH YOUR SPOUSE/PARTNERS SPERM

Spouse/Partners Name: _____

Spouse/Partners Date of Birth: _____ Age: _____

How long have you been together? _____ Occupation: _____

Does his work involve exposure to any toxins and/or chemicals? YES or NO

If yes, please list: _____

Does he have any children from a previous relationship? YES or NO

If yes, when: _____

Does he have any problems getting an erection? YES or NO If yes, _____% of the time?

Does he have any medical conditions? YES or NO

If yes, please list: _____

Does he take any medication regularly? YES or NO

If yes, please list: _____

Does he have any allergies to medication? YES or NO

If yes, please list: _____

Has he had any major surgeries: YES or NO

If yes, please list: _____

Has he ever had a sexually transmitted disease? YES or NO

If yes, when and which one? _____

Has he had a semen analysis? YES or NO

If yes, when and where? _____

Does he smoke? YES or NO

If yes, how much? _____

Does he drink alcohol? YES or NO

If yes, what amount and how often? _____

COMMUNITY PHYSICIANS NETWORK
AUTHORIZATION FOR RELEASE OF INFORMATION

FERTILITY SPECIALTY CARE
7250 Clearvista Drive, Suite #190
Indianapolis, IN 46256
Office # 317-621-0600
Fax # 317-621-0610

Patient Name: _____ SS # _____
Street Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Telephone: _____

- I agree to the release of health records and/or information as stated below.
- I understand that I may refuse to sign this form and that not signing this form will not affect my services, treatment or payment for services; unless the services are only to create an record for someone else, such as a physical exam or drug testing for an employer or insurance company; or if services are for research-related and your signature is required so that your results can be used for the research.
- I understand that I may see and copy the information described in this form if I ask for it.
- Unless listed below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2)* or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding **alcohol and/or substance abuse*, communicable disease documentation, human immunodeficiency virus (HIV) or mental health treatment or counseling.**

I authorize Fertility Specialty Care to (circle one) release information to OR obtain information from:
Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Phone Number: _____ Fax Number: _____

The purpose or need for this disclosure: ____ At the request of the individual ___ Other (specify) _____

Date(s) of information to be disclosed: (please circle): All records or List Specific Dates: _____

Information to be disclosed:
___ Office Notes ___ X-Ray Report ___ Emergency Room ___ All Records ___ Other _____

I understand this Authorization is voluntary and I have the right to revoke it at any time prior to its expiration date by written notification to _____ (name of releasing entity). This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that the information released may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

The expiration date for this release is 60 days from the signature date.

Information to be released: ___ verbally ___ photocopy/mailed ___ faxed ___ other _____

_____ _____
Patient Signature (or Parent/Guardian/Representative) Date

_____ _____
Printed name of Parent/Guardian/Representation Legal Authority of Representative

*Drug and alcohol abuse records are protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFS Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuses patient.