New Patient Medical History

Initial Appointment Date: ____/____/20_____

Name: _____ Age: _____ years Birth Date: ____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Primary phone: (_____) _____-_____ Alternative phone: (_____) _____-_____ SS#: _____-_____-_____

Email address: _____@_____._____

Occupation: _____ Marital status: S M W D Religion: _____ Race: _____

Partner's name: _____ Race: _____ Primary phone: (_____) _____-_____

Partner's occupation: _____ Partner's sex: Male Female Prefer not to answer

Referring physician: _____ City: _____ State: _____

Emergency contact (not living with you): _____ phone: (_____) _____-_____

Reason for Visit (please check all that apply)

_____ Infertility _____ IVF/INVOcell _____ Donor Eggs _____ Donor Sperm

_____ Repeated miscarriages _____ Irregular periods _____ other (_____)

Menstrual History

Are your cycles usually regular? _____ How painful are your periods? None mild moderate severe

What is the average length of your menstrual cycle (from the 1st day of one period till the 1st day of the next)? _____days

When was your last normal period? ____/____/_____ Do you bleed between periods? _____

Do you have excessive hair growth? _____ If yes, where: _____

Do you bleed after intercourse? _____ Is intercourse painful? _____

How often do you have intercourse per week? _____ Do you have a breast discharge? _____

Has your weight changed in the past year? _____ If yes, please describe: _____

When was your most recent: Pap smear? ____/____/_____

Past Medical History

List all injuries/illness requiring hospitalization:

Date	Reason
_____	_____
_____	_____
_____	_____

List all surgeries you have had:

Date	Reason
_____	_____
_____	_____
_____	_____

List any sexually transmitted disease you have had (such as, syphilis, gonorrhea, herpes, genital warts, PID, tubal infections): _____

Alcohol use: Current: _____beverages/day Past: _____beverages/day

Cigarette use: Current: _____cigarettes/day Past: _____cigarettes/day

Vape use: Current: _____times/day Past: _____times/day

Recreational/illegal drug use (please specify): Current: _____ Past: _____

How many caffeinated beverages do you have per day? _____

Have you ever undergone chemotherapy or radiation (if yes, please explain)? _____

What medical allergies do you have? _____

What environmental or food allergies to you have? _____

Name: _____ Initial appt. date: ___/___/20____

Medications

Do you currently take a prenatal or multi-vitamin? _____ Type: _____

Please list all medications you are currently taking (**prescription and over-the-counter**) and the indication:

Medication	Frequency	Indication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Contraceptive History

Please check all types of birth control methods you have used (past or currently):

Type	Dates	Type	Dates
____ Birth control pills	(_____-_____)	____ Condoms	(_____-_____)
____ Implants	(_____-_____)	____ IUD	(_____-_____)
____ Depo-Provera	(_____-_____)	____ other _____	(_____-_____)

Obstetrical History

Please list all pregnancies (including ectopic, abortions, miscarriages, and deliveries):

#	Date	Type	Birth Weight	Sex	alive Yes/No	Complications

Family History

Were you adopted? _____

Please check the following in the appropriate box for the relative involved:

Problem	Mother	Father	Brother/Sister	Grandparent(s)	Children
Breast cancer					
Ovarian cancer					
Other cancer					
Thyroid disease					
Heart disease					
Diabetes					
High blood pressure					
Irregular periods					
Infertility					
Uterine fibroids					
Endometriosis					
Birth defects					
Overweight/Obesity					
Genetic Disorders					
Other					

Name: _____ Initial appt. date: ___/___/20____

Previous Infertility Evaluation and Treatment

Female: Please note the date and results of any of following tests you have had:

Test	Date	Results
Hysterosalpingogram (HSG)		
Saline Sonohysterogram (SIS/SHG)		
Laparoscopy		
Hysteroscopy		
Ovarian Reserve tests		
Hormone tests		
Progesterone level		

Please note any infertility medications you have taken:

Medication	When	# cycles	Dose	Did you conceive?
Clomiphene citrate (Clomid)				
Letrozole				
hCG (trigger) injections				
Daily fertility injections				
Metformin (Glucophage)				
Other (_____)				

Please note any fertility treatments you have had:

Procedures	When	# cycles	Where	Did you conceive?
Intrauterine insemination				
In Vitro Fertilization				
Other (_____)				

Provider Notes:

_____

_____

_____

_____

_____

Plan:

_____

_____

_____

_____

_____

Innovative Fertility Specialists
Permission to Release Personal Health Information
Female Patient

Patient's Name: _____ DOB: _____/____/_____

Any physician, staff, employee or representative of Innovative Fertility Specialists has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following physicians and/or other persons in order to facilitate and coordinate my care, treatment and payment:

Physician	Location

Name	Relationship	Phone number	Alternate Phone number

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke this permission by writing to Innovative Fertility Specialists or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

_____ _____ ____/_____/_____

Patient' signature Guardian signature (if minor) Date

Innovative Fertility Specialists
Insurance Registration Form
Female Patient

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone #'s: Primary: (____) _____ -_____ Alternative: (____) _____-_____ Work: (____) _____-_____

Email address: _____@_____._____

Date of Birth: ____/____/_____ ✓ Female

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

If married, Spouse's Name: _____ Spouse's Date of Birth: ____/____/_____

Spouse's Occupation: _____ Employer: _____

Responsible Party Information

Relationship to Patient: _____ □ Self

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security #: ____-___-_____ Telephone #'s: Home: (____) _____-_____ Work: (____) _____-_____

Cell: (____) _____-_____ Other: (____) _____-_____

Date of Birth: ____/____/_____ Occupation: _____ Employer: _____

Insurance Information—Please present your insurance cards and government-issued photo ID to the receptionist

Insurance Co. Name	Policy #	Group #	Effective Date	Policy Holder

I authorize the release and disclosure of any or all of my medical and treatment records or reports to any other health care provider who may be of assistance, in the opinion of Innovative Fertility Specialists, and/or for assisting in any reimbursement or medical benefits to which the patient may be entitled. I allow FAX and/or electronic transmission of my medical records, if necessary. I further authorize and request that insurance payments be made directly to Innovative Fertility Specialists should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of the assignment shall be considered as effective and valid as the original.

I acknowledge full financial responsibility for services rendered by Innovative Fertility Specialists. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I authorize treatment by Innovative Fertility Specialists providers and personnel.

I have ready and fully understand the above consent for release of medical information, insurance authorization, financial responsibility, and treatment.

_____ _____ ____/_____/_____

Patient's signature Guardian signature (if minor) Date

Notice of Privacy Practices
Female Patient

This notice describes how medical information about you may be used and disclosed and about how you can get access to this information. Please review it carefully.

The policy of Innovative Fertility Specialists is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of Innovative Fertility Specialists.

Individually identifiable health and personal information is any information obtained by Innovative Fertility Specialists in connection with providing healthcare treatment, obtaining payment, or related health care operations. This relates to past, present or future information that Innovative Fertility Specialists receives from you as our patient.

Innovative Fertility Specialists collects personal information in order to learn about your medical history and conditions, render treatment, and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow-up and appointment reminders, as well as treatment alternatives or other health-related benefits. We may leave a message on your voice mail to contact you about appointments or to have you call our office. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to efficiently coordinate your treatment plan. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. As required by your insurance contractor, we will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, pre-certification, utilization review and related activities. For worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our practice management computer system. We also maintain information about you in your medical chart. Innovative Fertility Specialists limits the access to your protected health information to those employees and business associates who need to know that information. You generally have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

Your medical information may be reviewed by our medical staff for possible inclusion and referral in our research studies.

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to the Innovative Fertility Specialists Privacy Officer.
- Federal, state or other applicable law requires us to share protected information or records.

We are obligated to abide by the terms of this notice. If, at any time in the future, it is necessary to disclose any of your personal information in a way that is materially different from this policy, Innovative Fertility Specialists will give you notice of the change through a mailed announcement or on your visit following the change.

With some exceptions, you have the right to review and obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the rights to request your records be amended, to request special accommodations and restricts of your health information and to receive an accounting of the disclosures of your information. You have the right to request to receive confidential communications of your information. Innovative Fertility Specialists is not obligated to agree to a requested restriction.

Notice of Privacy Practices—Female Patient, page 2/2

We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, contact the Privacy Officer at 205-509-0700. You have the right to file a complaint with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation for filing a complaint.

I have read and received a copy of this information.

_____ ____/____/20____ _____

Patient signature Witness

Authorization for Release of Medical Information Female Patient

Please send my **complete** medical records to:

Innovative Fertility Specialists—An INVOcenter
130 Inverness Plaza, #120
Birmingham, AL 35242

Ph: 205-509-0700
Fax: 205-509-0724

Items needed: **Complete Medical Records including laboratory results, medications, and semen analysis reports**

Purpose of release: _____

I understand that:

1. This authorization is voluntary. I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected.
2. This authorization will remain in effect for one (1) year or until I revoke it in writing, which I may do at any time.
3. My records may contain hepatitis and HIV screening results that may be included in the record release.
4. The sender of this health information cannot guarantee that the recipient of the information will not re-disclose this information.
5. I have the right to receive a copy of this authorization form after I sign it.

Patient Name: _____ _____ ___
Last First MI

Patient Date of Birth: ____/____/_____

Spouse Name: _____ _____ ___
Last First MI

Spouse Date of Birth: ____/____/_____

Telephone #: (_____) _____-_____

Patient Signature: _____ Date: ____/____/_____

INNOVATIVE FERTILITY SPECIALISTS
An INVOcenter

Male Partner Medical Information

Male Partner Name: _____ Initial appt. date: ____/____/20_____

Email address: _____@_____._____ Current age: _____ years

Date of Birth: _____/_____/_____ Occupation: _____

Primary Care Provider: _____ Location: _____

Race/Ethnicity: _____

Previous vasectomy? Yes (date: _____) No If yes, has vasectomy been reversed? Yes No

History of infertility in a prior relationship? Yes No Number of pregnancies in prior relationship(s): _____

Number of pregnancies with present spouse: _____

List any sexually transmitted disease you have had (such as, syphilis, gonorrhea, herpes, genital warts, HPV, HIV):

_____

Tobacco Use:

Have you ever smoked cigarettes? Yes No If yes, when did you quit? _____

Number of cigarettes per day currently? _____ If more than 1, how many years have you smoked? _____

Do you dip or chew tobacco? Yes No Number of times vaping per day: _____

Number of alcoholic beverages per day? _____

Recreational/illegal drug use (please specify): Current: _____ Past: _____

Have you ever undergone chemotherapy or radiation (if yes, please explain)? _____

_____

Do you have a family history of (please circle): Infertility Miscarriage Birth defects Intellectual disability

Please list all current medications: _____

Have you EVER used any form of testosterone or body building supplements? Yes No

If yes, when/how long/last dosage: _____

Please list all medication allergies: _____

Urological evaluation of infertility? Yes No

If yes, who? _____ When: _____

Have you had a semen analysis? _____ When: _____ Result: _____

Provider Notes:

_____

_____

_____

_____

Plan:

_____

_____

_____

_____

Innovative Fertility Specialists
Permission to Release Personal Health Information
Male Patient

Patient's Name: _____

Any healthcare provider, staff member, employee or representative of Innovative Fertility Specialists has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following physicians and/or other persons in order to facilitate and coordinate my care, treatment and payment:

Physician	Location

Name	Relationship	Phone number	Alternate Phone number

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke this permission by writing to Innovative Fertility Specialists or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

_____ Patient' signature

_____ Guardian signature (if minor)

____/_____/_____ Date

Innovative Fertility Specialists
Insurance Registration Form
Male Patient

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: (____) _____-_____ Secondary phone: (____) ____-_____

Date of Birth: ____/____/_____ ✓ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Separated

Occupation: _____ Employer: _____

Partner's Name: _____ Partner's Date of Birth: ____/____/_____

Responsible Party Information

Relationship to Patient: _____ □ Self

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security #: ____-___-_____ Telephone #'s: Home: (____) _____-_____ Work: (____) _____-_____

Cell: (____) _____-_____ Other: (____) _____-_____

Date of Birth: ____/____/_____ Occupation: _____ Employer: _____

Insurance Information—Please present your insurance cards and government-issued photo ID to the receptionist

Insurance Co. Name	Policy #	Group #	Effective Date	Policy Holder

I authorize the release and disclosure of any or all of my medical and treatment records or reports to any other health care provider who may be of assistance, in the opinion of Innovative Fertility Specialists, and/or for assisting in any reimbursement or medical benefits to which the patient may be entitled. I allow FAX and/or electronic transmission of my medical records, if necessary. I further authorize and request that insurance payments be made directly to Innovative Fertility Specialists should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of the assignment shall be considered as effective and valid as the original.

I acknowledge full financial responsibility for services rendered by Innovative Fertility Specialists. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I authorize treatment by Innovative Fertility Specialists physicians and personnel.

I have ready and fully understand the above consent for release of medical information, insurance authorization, financial responsibility, and treatment.

_____ _____ ____/_____/_____

Patient's signature Guardian signature (if minor) Date

Authorization for Release of Medical Information Male Partner

Please send my **complete** medical records to:

Innovative Fertility Specialists—An INVOcenter
130 Inverness Plaza, #120
Birmingham, AL 35242

Ph: 205-509-0700
Fax: 205-509-0724

Items needed: **Complete Medical Records including laboratory results, medications, and semen analysis reports**

Purpose of release: _____

I understand that:

6. This authorization is voluntary. I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected.
7. This authorization will remain in effect for one (1) year or until I revoke it in writing, which I may do at any time.
8. My records may contain hepatitis and HIV screening results that may be included in the record release.
9. The sender of this health information cannot guarantee that the recipient of the information will not re-disclose this information.
10. I have the right to receive a copy of this authorization form after I sign it.

Patient Name: _____ _____ ___
Last First MI

Patient Date of Birth: ____/____/_____

Spouse Name: _____ _____ ___
Last First MI

Spouse Date of Birth: ____/____/_____

Telephone #: (_____) _____-_____

Patient Signature: _____ Date: ____/____/_____

Notice of Privacy Practices
Partner

This notice describes how medical information about you may be used and disclosed and about how you can get access to this information. Please review it carefully.

The policy of Innovative Fertility Specialists is to protect the confidentiality, integrity and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of Innovative Fertility Specialists.

Individually identifiable health and personal information is any information obtained by Innovative Fertility Specialists in connection with providing healthcare treatment, obtaining payment, or related health care operations. This relates to past, present or future information that Innovative Fertility Specialists receives from you as our patient.

Innovative Fertility Specialists collects personal information in order to learn about your medical history and conditions, render treatment, and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow-up and appointment reminders, as well as treatment alternatives or other health-related benefits. We may leave a message on your voice mail to contact you about appointments or to have you call our office. As part of our standard treatment and healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to efficiently coordinate your treatment plan. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. As required by your insurance contractor, we will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, pre-certification, utilization review and related activities. For worker's compensation, information about a work-related condition can be exchanged with the employer.

Your information is maintained in our office in our practice management computer system. We also maintain information about you in your medical chart. Innovative Fertility Specialists limits the access to your protected health information to those employees and business associates who need to know that information. You generally have the right to inspect, amend, copy and receive an accounting of disclosures of your medical and billing records.

Your medical information may be reviewed by our medical staff for possible inclusion and referral in our research studies.

We do not disclose personal information to third parties unless one of the following exceptions applies:

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates and signed by the patient (or guardian). You may revoke this authorization by providing a written statement to the Innovative Fertility Specialists Privacy Officer.
- Federal, state or other applicable law requires us to share protected information or records.

We are obligated to abide by the terms of this notice. If, at any time in the future, it is necessary to disclose any of your personal information in a way that is materially different from this policy, Innovative Fertility Specialists will give you notice of the change through a mailed announcement or on your visit following the change.

With some exceptions, you have the right to review and obtain a copy of your health information. This request must be in writing and there may be a reasonable charge to provide you with a copy of your information. You also have the rights to request your records be amended, to request special accommodations and restricts of your health information and to receive an accounting of the disclosures of your information. You have the right to request to receive confidential communications of your information. Innovative Fertility Specialists is not obligated to agree to a requested restriction.

Notice of Privacy Practices—Male Partner, page 2/2

We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, contact the Privacy Officer at 205-509-0700. You have the right to file a complaint with the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation for filing a complaint.

I have read and received a copy of this information.

_____ ____/____/20____ _____

Patient signature Witness