Idaho Center for Reproductive Medicine

111 Main Street Suite # 100 / Boise, ID 83702 (208) 342-5900.

PATIENT INFORMATION

PATIENT	PARTNER
SOCIAL SECURITY NO.	SOCIAL SECURITY NO.
NAME (FIRST, MIDDLE INITIAL, LAST)	NAME (FIRST, MIDDLE INITIAL, LAST)
ADDRESS	ADDRESS (IF DIFFERENT FROM PATIENT)
CITY/STATE/ZIP	CITY/STATE/ZIP
HOME PHONE / WORK PHONE / CELL PHONE	HOME PHONE / WORK PHONE / CELL PHONE
DATE OF BIRTH / AGE / SEX / MARRIED/SINGLE/TOGETHER	DATE OF BIRTH / AGE / SEX / MARRIED/SINGLE/TOGETHER
EMERGENCY CONTACT INFORMATION	**EMERGENCY CONTACT INFORMATION**
CONTACT / RELATIONSHIP	DAY TIME PHONE / EVENING PHONE
PATIENT'S EMPLOYMENT	**PARTNER EMPLOYMENT**
COMPANY NAME / OCCUPATION	COMPANY NAME / OCCUPATION
ADDRESS	ADDRESS
CITY/STATE/ZIP	CITY/STATE/ZIP
PRIMARY OR PATIENT'S INSURANCE	**SECONDARY OR PARTNER INSURANCE**
INSURANCE COMPANY NAME	INSURANCE COMPANY NAME
P.O. BOX/ADDRESS	P.O. BOX/ADDRESS
CITY/STATE/ZIP	CITY/STATE/ZIP
POLICY I.D. NUMBER / GROUP NO.	POLICY I.D. NUMBER / GROUP NO.
SUBSCRIBER NAME / DO YOU HAVE FERTILITY COVERAGE?	SUBSCRIBER NAME
REFERRING PHYSICIAN/OTHER FORM OF REFFERAL	**OTHER CONTACT INFORMATION**
NAME	Patient email address:
ADDRESS	Partner email address:
CITY/STATE/ZIP	Other:
PHONE	

Your records are considered confidential information and we will not release any information without your consent and signature. Please sign the release below.

If needed, I hereby authorize the Idaho Center for Reproductive Medicine to release information to myself, my insurance carrier, an Independent audit agency or to my physician. I also authorize my insurance carrier to reimburse the Idaho Center for Reproductive Medicine for services rendered.

DATE ______________ PATIENT ______________________________

DATE ______________ PARTNER ______________________________

HIPPA consent (Initial Please) ____________

FEMALE PATIENT HISTORY

NAME ______________________________ Date ______________
Weight ______________ Height ______________ Blood Type (if known) ________
When was the first day of your last period? ______________
Are your periods regular? ______________ If yes, how many days between periods? ________
If no, how many times per year do you menstruate? ________
What is the usual duration of your menses? ______________
What medications do you regularly take? (prescription and/or over-the-counter)
______________, ______________, ______________, ______________,
______________, ______________, ______________, ______________

Do you or have you ever used:
Alcohol? How many drinks per week? ______________
Cigarettes? How many packs per day? ______________
Illicit or recreational drugs? ______________

How long have you been trying to get pregnant? ______________
Past history (if applicable):

	Year	Born Alive?	Miscarriage?	Abortion?	Ectopic?	Fert Drugs Required?	Current Partner?
1st pregnancy							
2nd pregnancy							
3rd pregnancy							
4th pregnancy							
5th pregnancy							

Has your partner ever fathered a child? ______________
Have you ever been treated for infertility? ______________
If yes, please review diagnostic studies and treatments with our physician during your appointment.
Please list all types and dates of surgeries you have undergone:

Family history of blood clotting disorders? ______________
If yes, please explain ______________

Do you or have you ever had (circle all that apply):
Allergies? (circle) yes or no If yes please list; ______________
Have you ever been treated for cancer? ______________

Anemia
Appendicitis
Arthritis
Blood transfusion
Breast discharge
Breast soreness
Cancer? Specify ______________
Chlamydia
Chronic headaches
Colitis
Color blindness
Diabetes
Dizziness
Endometriosis
Epilepsy
Gallbladder problems
Gonorrhea
Heart disease
Hepatitis
Herpes
Hirsutism (excess hair growth)
High blood pressure
Immunization: German Measles
Kidney infection
Liver problems
Loss of balance
Measles: German
Measles: Regular
Neurological problems
Nongonococcal urethritis
Ovarian Cysts
Parasitic infection
Pneumonia
Poor sense of smell
Rheumatic fever
Scarlet fever
Seizures
Syphilis
Thyroid problems
Tuberculosis
Ulcers
Vaginitis (trichomoniasis, yeast)
# of episodes ________
Visual disturbances

Countries of origin: Mother's family: ____________________ Father's family: ____________________

Ethnic background (Circle) : African American Asian Asian-Indian Caucasian Hispanic

Jewish American-Indian Mediterranean Middle Eastern
Other: ____________________

Ethnic Group (Check all that apply)	**Have you ever been tested for:**	**Yes**	**No**	**Date**	**Result**
African, African/American	Sickle cell trait				
Chinese, Southeast Asian, Mediterranean (Greek or Italian) or Hispanic	Thalassemia				
Caucasian, Jewish	Cystic Fibrosis				
Jewish	Bloom Syndrome,				
	Canavan Familial Dysautonomia (FD),				
	Fanconi Amemia (type C),				
	Gaucher Disease (Type I),				
	Glycogen Storage (Type 1a),				
	Maple Syrup Urine Disease,				
	Mucolipidosis, (Type IV ML IV),				
	Niemann - Pick Type A,				
	Tay Sachs				

Other inherited disorders? ____________________

Would you like to be tested for the test recommended for your specific ethnic group? (Circle) **Yes** **No**

Are you related to your spouse (consanguinity)? ____________________

Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed (Circle)? **Yes** **No**

MALE PATIENT HISTORY

Date _______________

Name____
Weight___________________ Height ____________________ Blood Type (if known) _________
Are you, or have you ever been exposed to any of the following during employment or military service?
If so, please explain,

Heat_______________________________ Toxic fumes________________________________
Chemicals__________________________ Nuclear radiation____________________________
Other____

What medications do you regularly take? (Prescription and/or over the counter drugs)
____
____

Do you frequently take saunas or steam baths?____
Do you or have you ever, used:

Alcohol? How many drinks per week?___________________
Cigarettes? How many packs per day?___________________
Illicit or recreational drugs?____

Have you ever been treated for infertility in the past?____

If yes, please review diagnostic studies and treatments with our physician during your appointment.

Please list all types and dates of surgeries you have undergone:____________________________________
____

Allergies? (circle) yes or no If yes, please list:____
Have you ever been treated for cancer? ____
Family history of blood clotting disorders? ____
If yes, please explain? ____

Do you, or have you ever, had (circle all that apply):

Anemia	Gonorrhea	Parasitic infection
Appendicitis	Heart disease	Pneumonia
Arthritis	Hepatitis	Prostatitis
Bleeding disorder	Herpes	Rheumatic fever
Blood transfusion	High blood pressure	Scarlet fever
Chlamydia	Kidney infection	Seizures
Chronic bronchitis	Liver problems	Syphilis
Chronic headaches	Loss of balance	Testes infection
Colitis	Measles: German	Testes injury
Cystic Fibrosis	Measles: Regular	Testes tumor
Diabetes	Mumps	Thyroid problems
Dizziness	Mumps w/testes involved	Tuberculosis
Epilepsy	Neurological problems	Visual disturbances
Gallbladder problems	Nongonococcal urethritis	Cancer (specify)________________________

Countries of origin: Mother's family: ____________________ Father's family: ____________________________

Ethnic background (Circle) : African American Asian Asian-Indian Caucasian Hispanic

Jewish American-Indian Mediterranean Middle Eastern
Other: ______________________

Ethnic Group **(Check all that apply)**	**Have you ever been tested for:**	**Yes**	**No**	**Date**	**Result**
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	Gaucher Disease (Type I),				
	Glycogen Storage (Type 1a),				
	Maple Syrup Urine Disease,				
	Mucolipidosis, (Type IV ML IV),				
	Niemann - Pick Type A,				
	Tay Sachs				

Other inherited disorders? ____

Would you like to be tested for the test recommended for your specific ethnic group? (Circle) **Yes** **No**

Are you related to your spouse (consanguinity)? ______________________________

Fragile X testing is recommended if the exact etiology of the mental retardation is unknown. Would you like this testing performed (Circle)? **Yes** **No**

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ICRM Notice of Privacy & Security Practices

This following information explains how your personal health information might be used or disclosed and how you can attain access to this information. Please review this information carefully.

Uses and Disclosures
Medical Action: Your information may be used by ICRM or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Health Care Operations: Your protected health information may be used as necessary to support the day-to-day activities and management of ICRM. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Law Enforcement Officials: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting and Officials: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information
Appointment reminders. Your health information may be used by our staff to send you appointment reminders.

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Signature

I have reviewed this HIPPA consent form and give my permission to ICRM to use and disclose my health information in accordance with it.

Name of Patient (Print)

Name of Partner (Print)

Signature of Patient

Signature of Partner

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

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Request for Confidential Communication of Protected Health Information.

I, ______________________________ give ICRM permission to disclose medical
(Patient's Name - Please Print)

information and/or test results to ____.

Please list the relationship to the patient: ___________________________________.

______________________________ ____________________
(Patient's Signature) (Date)

I, ______________________________ give ICRM permission to disclose medical
(Patient's Name - Please Print)

information and/or test results to ____.

Please list the relationship to the patient: ___________________________________.

______________________________ ____________________
(Patient's Signature) (Date)

Credit Card Authorization

I,_____________________________, give ICRM permission to charge my Credit card and keep this card on file for future visits. I would like to pay With a Visa/Mastercard #____

And expiration date of _____/_____.

____

Signature

____

Date

Comments:____

____

____

Idaho Center for Reproductive Medicine

Russell A. Foulk, M.D.
Reproductive Endocrinology & Fertility

Cristin C. Slater, M.D.
Reproductive Endocrinology & Fertility
Medical Director

111 Main Street Suite # 100
Boise, Idaho 83702
Phone # (208) 342-5900
Fax # (208) 342-2088

Authorization to Release Medical Records

Patient Name:____

Date of Birth:__________________ SS# __________________

FROM: ____

____

____

TO: ____

____

____

I hereby authorize and request the release of the following information:

______ All Medical Records

______ Medical record information for visit date of __________ to __________.

______ Progress Notes

______ Lab reports

______ Hospital and/or Operative reports

______ Other: ____.

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment, and infertility treatment. I give authorization for these records to be released.

Signature: ________________________________ Date: ____________

Signature (Partner): __________________________ Date: ____________