ADVANCED FERTILITY CENTER OF CHICAGO
New Patient Registration Form

Date_____ How did you hear about our fertility center?_____

Reason for your consultation today? _____

Female Patient Name _____
Last Name First Name Middle Name or Initial

Home Phone _____ Work Phone _____ EXT # _____ Cellular Phone_____

Home Address _____

City_____ State _____ Zip code_____

Age _____ Date of birth_____ Marital Status _____ Email address _____

Employer Name_____ Occupation _____

In case of emergency whom should we contact? _____ Phone Number _____

Female Patient Primary Insurance Co._____ Subscriber Name (e.g. My husband)_____

Insured ID Number _____ Group Number _____

Do you have secondary insurance coverage? _____ If so, please provide information below.

Female Patient Secondary Insurance Co._____ Subscriber Name (e.g. My husband)_____

Insured ID Number _____ Group Number _____

****

Partner Name _____
Last Name First Name Middle name or initial

Home Phone _____ Work Phone _____ EXT # ____ Cellular Phone_____

Home Address _____

City _____ State_____ Zip code _____

Age _____ Date of birth _____ Marital Status _____Partner Email address _____

Employer Name _____ Occupation _____

Partner's Primary Insurance Co._____ Subscriber Name _____

Insured ID Number _____ Group Number _____

Female History

Allergies to medications: _____ Primary pharmacy name and phone #: _____

Who is your current gynecologist? _____ When did you last see him/her? _____

The American Congress of Obstetricians and Gynecologists recommends all women attempting pregnancy do genetic screening to see if they are a carrier for cystic fibrosis. Other genetic tests are also recommended based on ethnic background.
Female partner's ethnic background is_____
Male partner's ethnic background is_____
Are you of Eastern European Jewish descent (Ashkenazi)? _____
Are you of French Canadian or Cajun descent? _____
Are you of African descent?_____
Are you of Mediterranean descent?_____
Are you of Southeast Asian descent?_____

Check all that apply to you:

____ Abnormal pap smear	____ Irregular periods
____ Treatment for abnormal pap: LEEP, cryosurgery, cone biopsy, laser of cervix	____ Tubal disease/surgery: Give details _____ _____
____ Tubal ligation (tubes tied)	____ Pelvic inflammatory disease
____ Bleeding between periods	____ Chlamydia or gonorrhea infection
____ Bleeding with intercourse	____ Nipple discharge
____ Breast lumps	____ Painful intercourse
____ Endometriosis	____ Urinary problems
____ Extreme menstrual pain	____ Vaginal discharge
____ Hot flashes	____ Vaginal infections

Menstrual History

Day one of last period_____ Date of last pap_____
Age at onset of first menstrual period_____
Frequency of menstrual periods (e.g. every 28-30 days)_____
Duration of bleeding (e.g. 4-5 days) _____
Menstrual cycle pattern: _____regular _____ irregular _____ no periods at all (or hardly ever)

Relationship History

Are you legally married _____If so, how long have you been married?_____
How long have you been trying to get pregnant?_____
Any difficulty conceiving with prior pregnancies?_____
Frequency of intercourse (per month)_____
Any problems with intercourse, male erection or ejaculation?_____
Do you use any lubricants with intercourse? _____

Pregnancy History

Number of previous pregnancies_____ Number of live births_____Dates of live births_____
Previous miscarriages (#)_____ Dates and number of weeks at time of loss _____
Previous ectopic (tubal) pregnancies Dates _____
Previous elective abortions (#)_____ Dates _____

Previous infertility testing / treatment

HSG (dye test) Date done _____ Were results normal? _____ Inseminations, how many and details _____
_____
In vitro fertilization - Please give dates and some details_____
_____

Other infertility tests and/or treatment: _____

Surgical history (dates and types of surgeries)_____

Female Medical History – List ***your*** **medical problems** (not your family)

All medical problems that you have had. Include important details_____

_____

Female Family Medical History – List ***your family's*** medical problems below

_☐ Cancer _☐ Diabetes _☐ Hypertension _☐ Heart disease _____Premature menopause

Other_____

Female Social History

Have you ever smoked? For how many years? _____ When did you quit?_____
Do you currently smoke? If so, how many packs a day? _____
Do you use alcohol? If so, how many drinks per day or week? _____
Do you use any recreational drugs? Which ones and how often? _____

Female Current Medications

Medication	Dose	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If there is anything else that you want to tell us, here is space for it:

_____
_____
_____

MALE HISTORY

NAME:_____ ALLERGIES: _____

History of pregnancies with previous partners: How many? _____ When? _____

SEMEN ANALYSIS RESULTS:

Test parameter:	Result:
Volume	
Count (Concentration)	
Motility	
Morphology	

Male Medical History – List ***your*** **medical problems** (not your family members)

All medical problems that you have had. Include important details_____

_____

Male Social History

Have you ever smoked? For how many years? _____ When did you quit?_____
Do you currently smoke? If so, how many packs a day? _____
Do you use alcohol? If so, how many drinks per day or week? _____
Do you use any recreational drugs? Which ones and how often? _____
Do you have any problems with erections, intercourse or ejaculation? _____

Male Current Medications
Are you taking a calcium channel blocker for high blood pressure? _____
Names of all medications you are taking:
_____

If there is anything else that you want to tell us, here is space for it:
_____
_____

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist.

How May I Pay? We accept payment by cash, check, VISA, MasterCard, American Express and Discover.
What Is My Financial Responsibility for Services? Your financial responsibility depends on several factors, some explained below.

If You Have…	You are Responsible For…	Our Staff Will…
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visits, blood work, ultrasounds, and other charges at the time of the office visit.	Call your insurance company ahead of time to determine deductibles and co-insurance. File an insurance claim on your behalf.
Plans with which we are contracted BlueCross/Blue Shield PPO Blue Choice United Healthcare Aetna Humana Cigna	If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is required at the time of the visit.	Call your insurance company ahead of time to determine deductibles and co-insurance. File an insurance claim on your behalf.
HMO plans with which we are not contracted.	Payment in full for office visits, blood work, ultrasounds and other charges at the time of the office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out of Network PPO.	Payment of the patient responsibility-deductible, copays, non-covered services at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services. File an insurance claim on your behalf.
Self Pay	Payment in full is required at the time of the visit.	Work with you to settle your account. Speak with our staff if you need further assistance.

If your insurance has not paid its portion within 90 day of claim submission, charges will be transferred to your responsibility. Balances that are 60 days or more past due are subject to an additional 18% annual interest charge.

If your physician recommends IVF, you will talk with one of our nurse coordinators. She will answer specific questions about the scheduling process, discuss the paperwork and tests involved, and complete all the pre-certification/authorization if your insurance company requires it.

Advanced Fertility Center will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. Our staff will explain a cost estimate that shows your financial responsibility based on the benefit levels and coverage of your insurance plan.

If at any time during your treatment it is determined that you are ineligible to receive insurance benefits due to non-payment of premiums, you may be required to pay for services upfront or we may require proof that your premiums have been paid.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance company to pay benefits directly to Advanced Fertility Center of Chicago. I authorize Advanced Fertility Center of Chicago to release pertinent medical information to my insurance company as required to facilitate payment of claims.

I authorize the use of my signature on all insurance submissions, whether manual or electronic.

I acknowledge receipt of Advanced Fertility Center of Chicago's Notice of Privacy Practices. My rights including the right to view and copy my record, to limit disclosure of my health information, and to request an amendment of my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent.

*Patient Signature*_____ *Date*_____

Printed name _____