PATIENT INFORMATION

FEMALE LEGAL NAME

_____ _____ Birthdate (mm/dd/yyyy)_____ Age ____
First Name Last Name

Home Phone (____)_____ Circle one: single engaged married
Cell Phone (____)_____ Social Sec #_____
Work Phone (____)_____ Email: _____
Employer _____ Occupation _____

MALE LEGAL NAME

_____ _____ Birthdate (mm/dd/yyyy)_____ Age ____
First Name Last Name

Home Phone (____)_____ Circle one: single engaged married
Cell Phone (____)_____ Social Sec.# _____
Work Phone (____)_____ Email: _____
Employer _____ Occupation _____

Home address _____
City, State, Zip _____

Referred by _____ Phone (____)_____

Nearest relative _____ Phone (____)_____

Insurance Co. _____ Name of insured _____
Address _____ Group number _____
_____ Policy number _____
Ins. Co. Phone (____)_____ ID number_____

Female Signature _____ Date signed _____
Male Signature _____ Date signed _____

Female) Race/Ethnicity

__ Hispanic or __ Not Hispanic
__ White
__ Black or African American
__ Asian
__ Native Hawaiian or other Pacific Islander
__ American Indian or Alaska Native
__ Refused

Male) Race/Ethnicity

__ Hispanic or __ Not Hispanic
__ White
__ Black or African American
__ Asian
__ Native Hawaiian or other Pacfic Islander
__ American Indian or Alaska Native
__ Refused

FEMALE MEDICAL QUESTIONNAIRE

This questionnaire must be completed & received prior to your initial consultation with Dr. Silber.

Date: _____

Name: _____
Last Name First Name Nickname

Date of Birth: _____ Height: _____ Weight: _____
mm/dd/yyyy feet/inches pounds

How long have you been together with current partner____? How long have you been married _____?
How long have you been trying to conceive _____?
How many pregnancies (including abortions) have you had? _____

	When? (Year)	End in Miscarriage?	End in Abortion?	End in Ectopic?	Infertility therapy required to conceive?	How long to conceive?	Baby born alive?	Is current partner the father?
1st pregnancy								
2nd pregnancy								
3rd pregnancy								
4th pregnancy								
5th pregnancy								

List dates and results of ultrasounds for infertility testing: _____

List dates and results of hysterosalpingograms: _____

List dates and results of laparoscopies or hysteroscopies: _____

List dates and results of hormone testing: _____

Age when first period occurred_____ Date of last period:_____
How many days apart are your periods (i.e: 28?, 30? Irregular?)_____
If irregular, how many periods per year?_____
Do you have a history of blood clots or family history of blood clots (maternal or paternal)?_____
If yes, please explain: _____

List all previous fertility treatment (i.e. IUIs, IVF, etc), where performed, and outcomes: _____
_____

List any other surgeries/hospitalizations you had in the past: _____
_____

List all medications or drugs you are currently taking, including over the counter medication. State how often and the reason for taking them: _____
_____

What form of contraception do you use currently:
Pills (name)?_____ IUD (name)?_____ Other?_____ None_____
Do you currently use tobacco products?_____ If yes, what kind and how much per day?_____
Do you drink alcoholic beverages?____ If yes, how much per day?_____
Do you use illicit drugs?_____ If Yes, please explain_____
Do you have any allergies to food, medications or other. Please list:_____
Please list any personal history of heart disease, cancer, diabetes, Hepatitis, STDs, UTIs, other:_____
Please list any family history of heart disease, cancer, diabetes, Hepatitis, other:_____

MALE MEDICAL QUESTIONNAIRE

This questionnaire must be completed & received prior to your initial consultation with Dr. Silber.

Date: _____

Name: _____
Last Name First Name Nickname

Date of Birth: _____ Height: _____ Weight:_____
mm/dd/yyyy feet/inches pounds

How long have you been together with current partner_____? How long have you been married _____?
How long have you been trying to conceive _____?

Have you ever fathered children?_____ If yes, please list dates, outcomes and current or previous partner:
_____

List dates and results of semen analyses: _____

List dates and results of hormone testing: _____

List any other surgeries/hospitalizations you had in the past (including vasectomy, reversals, varicocele):
_____
_____

List all medications or drugs you are currently taking, including over the counter medication. State how often and the reason for taking them: _____
_____
_____

Do you have trouble getting an erection?_____ Trouble maintaining an erection? _____
Do you have trouble with ejaculations? _____ If so, please explain:_____
Do you currently use tobacco products?_____ If yes, what kind and how much per day?_____
Do you drink alcoholic beverages?____ If yes, how much per day?_____
Do you use illicit drugs?_____ If Yes, please explain_____
Do you have any allergies to food, medications or other. Please list:_____
Please list any personal history of heart disease, cancer, diabetes, Hepatitis, STDs, UTIs, other:_____
Please list any family history of heart disease, cancer, diabetes, Hepatitis, other:_____
_____
_____

SHERMAN J. SILBER, M.D.
INFERTILITY CENTER OF ST. LOUIS

224 S. Woods Mill Road, Suite 730
Saint Louis, Missouri USA 63017
(314) 576-1400 • Fax: (314) 576-1442

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/INFORMATION

I, _____ (DOB: _____) (SSN: _____),

hereby authorize the **physician/medical office indicated below** to release copies of my medical/ treatment records:

Physician Name:_____

Street Address _____

City/State/Zip _____

Telephone: _____ Fax: _____

[ ]	Operative Reports	[ ]	IVF Summary Sheets
[ ]	History & Physical Reports	[ ]	Female Summary Sheet
[ ]	Laboratory Results	[ ]	Male Summary Sheet
[ ]	Ultrasound Reports	[ ]	Office Visit Notes
[ ]	Pathology Reports	[ ]	HIV, Hepatitis, STD Results

[ ] Other: _____

_____

_____

I authorize all of the information specifically indicated above as of the following dates of treatment _____ (begin date) through _____ (end date) to be released to the following physician/medical office:

Sherman J. Silber, M.D.
Infertility Center of St. Louis
224 S. Woods Mill Road, Suite 730
St. Louis, MO 63017
(314) 576-1400 (phone)
(314) 576-1442 (fax)

I understand that neither Sherman J. Silber, M.D., nor the Infertility Center of St. Louis, can force me to sign this authorization. I further understand that I may revoke this authorization at any time. The date of expiration for this authorization is as follows: _____. If no expiration date is given, this authorization will expire one year from the date the authorization is signed. I understand that I may request a copy of this signed authorization.

_____ _____

Signature of Patient Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, _____. have received a copy of The Infertility Center of St. Louis's Notice of Privacy Practices.

Printed Name of Patient	Printed Name of Partner
Signature of Patient Date Signed	Signature of Partner Date Signed

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason:

- ☐ Patient refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (please specify reason)

_____
_____
_____

Employee Signature	Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT VERY CAREFULLY.

This Notice of Privacy Practices describes the practices of The Infertility Center of St. Louis. We create a record of the care and services you receive at our center. We understand that information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at The Infertility Center of St. Louis.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. Not every use or disclosure is covered, but all of the ways that we are allowed to use and disclose information will fall into one of the categories.

YOUR HEALTH INFORMATION RIGHTS

Although your health information is the physical property of The Infertility Center of St. Louis, the information belongs to you. You have the right to:

Request restrictions on the way we use your medical information; request and receive information from us in a different way or manner; review your medical information; request that we amend your medical information; know how we have used or disclosed your medical information; revoke your authorization to use or disclose health information except to the extent that action has already been taken; obtain a paper copy of the Notice of Privacy Practices upon request;

You may exercise your rights set forth in this notice by providing a written request to The Infertility Center of St. Louis, Attn: Privacy Officer, 224 S. Woods Mill Road, Suite 730, St. Louis, MO 63017. Your written request must include the following: Your full name, date of birth or social security number, telephone number, detailed description of request, requester's name (if different from the patient), requester's relationship to the patient, and dated signature.

OUR RESPONSIBILITIES

The Infertility Center of St. Louis is required to:

Maintain the privacy of your health information; provide you with a notice as to our legal duties and privacy practices with regard to information we collect and maintain about you; abide by the terms of this notice currently in effect; notify you if we are unable to agree to a requested restriction; accommodate reasonable requests you may have to communicate health information by alternative means.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain at that time. Upon request, we will provide you with any revised Notice of Privacy Practices by mail or in person at the time of your next appointment.

We will not use or disclose your health information without your authorization except as described in this notice.

EXAMPLES OF DISCLOSURE FOR TREATMENT, PAYMENT, HEALTHCARE OPERATIONS AND AS OTHERWISE ALLOWED BY LAW

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what mean and try to give examples.

We will use your health information for treatment. For example, we may disclose medical information about you to other doctors, nurses, technicians, medical students, or other personnel who are involved in your care with The Infertility Center of St. Louis. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work, and ultrasound. We may also disclose medical information about you to people outside of our center or St. Luke's Hospital who may be involved in your medical care or who provide services that are part of your care.

We will use your health information for payment. Your protected health information will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves, denies, or pays for your healthcare services, such as making a determination of eligibility or coverage, reviewing medical records to determine medical necessity, and undertaking utilization review activities. A receipt or invoice may also be sent to you or a third-party payer. The information on or accompanying the receipt or invoice may include information that identifies you, as well as your diagnosis and procedures.

We will use your health information for regular health care operations. For example, we may use the information in your health records to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. We can use or disclose protected health information about you without your authorization when there is an emergency or when we are required by law to treat you; when we are required by law to disclose certain information; or when there are substantial communication barriers to obtaining consent from you. Further, we may use or disclose your protected health information without your consent or authorization in any of the following circumstances:

When it is required by law; when it involves use and disclosure for public health activities, such as mandated disease reporting, etc.; when reporting information about victims of abuse, neglect or domestic violence; when disclosing information for the purpose of health oversight activities, such as audits, investigations, licensure, or disciplinary actions or legal proceedings or actions; when disclosing information for law enforcement purposes, for instance, to locate or identify a suspect, fugitive, witness or missing person or regarding a victim of a crime who cannot give consent or authorization due to incapacity; when disclosing information about deceased persons to medical examiners, coroners and funeral directors; when disclosing or using information for organ and tissue donation purposes; when disclosing information related to a research project when a waiver of authorization has been approved by the Investigational Research Body; when we believe in good faith that the disclosure is necessary to avert a serious health or safety threat to you or to the public's safety; when disclosure is necessary for specialized government functions, such as military service, for the protection of the President or for national security and intelligence activities; when required by military command authorities, if you are a member of the armed forces (or if foreign military personnel, to appropriate foreign military authorities); when in the case of a prison inmate, information can be released to the correctional facility in which he or she resides for the following purposes: (1) for the institution to provide the inmate with health care; (2) to protect the health and safety of others; or (3) for the safety and security of the correctional facility; and when disclosure is necessary to comply with Worker's Compensation laws or purposes.

We may use medical information to:

Contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you, and instructions regarding scheduled treatment.

PLANNED USES OR DISCLOSURES TO WHICH YOU MAY OBJECT

We will use or disclose your health information for purposes described in this section unless you object to or otherwise restrict a particular release. You must direct your written objections or request for restrictions to The Infertility Center of St. Louis, Attn: Privacy Officer, 224 S. Woods Mill Road, Suite 730, St. Louis, MO 63017.

We may use or disclose your health information to contact you and remind you about an appointment for treatment or medical care; to provide you with information about our recommendations for possible treatment options or alternatives that may interest you; for scheduling tests, procedures, and treatments with other providers.

We may release health information about you to a friend and/or family member who is involved in your care. If you are available, you may object and we will not make these disclosures. If you are not available, we will determine whether a disclosure to your family and friends is in your best interest. We will disclose only health information that is directly relevant to their involvement in your care.

We can tell your family and/or friends of your condition and that you are using The Infertility Center of St. Louis for treatment and services. We can also give this information to someone who will help or is helping pay for your treatment or care.

We can disclose health information about you to a public or private entity that is authorized by law or its charter to assist in disaster relief efforts, i.e., the American Red Cross for the purpose of notification of family and/or friends of your whereabouts and condition.

OTHER USES OR DISCLOSURES

Uses or disclosures not covered in the Notice of Privacy Practices will not be made without your written authorization. If you provide us written authorization to use or disclose information, you can change your mind and revoke your authorization at any time, as long as it is in writing. If you revoke your authorization, we will no longer use or disclose the information. However, we will not be able to take back any disclosures that we have made pursuant to your previous authorization. Written revocations should be sent to The Infertility Center of St. Louis, Attn: Privacy Officer, 224 S. Woods Mill Road, Suite 730, St. Louis, MO 63017.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

You may contact The Infertility Center of St. Louis, Attn: Privacy Officer, 224 S. Woods Mill Road, Suite 730, St. Louis, MO 63017, or by phone at 314-576-1400, regarding questions on this Notice of Privacy Practices, requests for personal disclosure of documentation, or potential violations of your privacy rights.

You may also file a complaint with the United States Secretary of Health and Human Services (HHS). You will not be retaliated against for filing a complaint with either The Infertility Center of St. Louis of the United States Department of Health and Human Services.

Effective 4/14/03