

The Fertility Institutes
Gender Selection Program
16030 Ventura Boulevard, 4th Floor
Encino, Ca 91436
818-728-4600
800-222-2802

Thank you for your interest in the PGD based gender selection program conducted by the Fertility Institutes in Los Angeles.

Our program is a world leader in providing those interested in achieving a pregnancy of a desired gender (sex) a near 100% (99.99%) chance of assuring that a pregnancy achieved using our PGD technology will result in the pre-selected gender outcome.

The attached documents have been compiled and provided in advance to allow you time to complete the necessary paperwork prior to your visit to our facility. Please fill out all of the forms to the best of your ability and bring the completed forms to your appointment. This will allow us the opportunity to assure that the time provided for you with us can be spent introducing you to all of the important details of our program. Feel free to call should you have any questions or concerns filling out the paperwork.

The Fertility Institutes conduct the world's largest and busiest PGD based sex selection program. The physicians, scientists and technical staff at the Center have appeared on over 60 national and international news programs, detailing the success with sex selection at The Fertility Institutes. Services have been provided to people from over 40 nations on every continent.

In addition to providing gender related genetic testing of embryos, we offer comprehensive preimplantation genetic screening for over 200 different genetic diseases. Through our affiliation with the world's leading genetic diagnosis centers, we offer the ability to screen embryos for a wide array of genetic disorders that may be associated with either known or suspected genetic disease, recurrent miscarriage, unexplained infertility or failed prior in vitro fertilization attempts.

Our andrology (male reproduction) center has the ability to prescreen the sex ratio (number of "boy" producing sperm and number of "girl" producing sperm) found in the semen of a father to be. By carefully analyzing these ratios, we are able to offer interested individuals a picture of their chances of achieving a pregnancy of one gender or the other.

Thank you once again for your interest in our program and rest assured that you are in contact with a world leader in the provision of reproductive options and family balancing.



The Fertility Institutes
Helping Couples Become FamiliesSM

Patient Registration

Name: _____ DOB: _____ Age: _____ Sex: F M

Maiden Name: _____ Email Address: _____

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

Home Phone: _____ Cell: _____ Fax: _____

SS# _____ Driver's License # _____

Employer: _____ Occupation: _____

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

Work Phone: _____ Emergency Contact: _____ Phone: _____

Spouse or Guarantor: _____ Relationship: _____

Age: _____ Sex: F M Driver's License# _____

Address: _____ SS# _____ DOB: _____
(if not same as above)

Home Phone: _____ Cell: _____ Fax: _____

Employer: _____ Occupation: _____

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

Insurance Company: _____ Subscriber #: _____

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

Phone: _____ Adjuster: _____

Policy ID's (Group, Certif., Policy #'s): _____

Credit and Collections Policy

Payment for all services rendered is expected at the time of service. You will be issued a receipt at the time of payment that contains all of the information required by insurance companies for consideration of reimbursement. VISA, MASTERCARD and AMERICAN EXPRESS credit cards may be used for payment if so desired. Bank transfers are also accepted. Overdue accounts are subject to interest charges at 60 days. At 90 days, overdue accounts may be referred to a third party collection agency. These agencies are nationwide and international credit collection services. Once referred for collection, we forfeit the ability to further manage or discuss your account with you. Because of this, you are urged to bring any billing disputes to our attention as soon as noted. Delinquent account reports WILL adversely impact the credit ratings of affected individuals.

Credit Inquiry Authorization: _____
(required signature)

Referred by: _____ Address: _____
Phone # _____ Medical Problem: _____

Name _____ Age _____ Single/Married _____ Divorced/Widow(er) _____ Date _____

Occupation _____ All Previous Occupations _____

Birth Place _____ Date of Birth _____ List all states in which you have lived: _____

Education _____ # years High School: _____ # years College: _____ # years Post Grad: _____

Date of last physical examination _____

Please list any symptoms that may be bothering you (if any)

1. _____
2. _____
3. _____
4. _____
5. _____

Fertility Intake Form; No Symptoms

THIS FORM IS A GENERAL HEALTH HISTORY. THERE MAY BE A SEPARATE HISTORY FORM ATTACHED WITH MORE DETAILED QUESTIONS RELATED TO YOUR SPECIFIC CONDITION(S). PLEASE FILL OUT ALL HISTORY FORMS TO THE BEST OF YOUR ABILITY
 P.I. Please do not write in this space

	If Living		If Deceased		Cause	Has any blood relative ever had	Please circle		Who
	Age	Health	Age at death				No	Yes	
Father						Cancer	No	Yes	
Mother						Tuberculosis	No	Yes	
Brother or Sister 1.						Diabetes	No	Yes	
2.						Heart Trouble	No	Yes	
3.						High Blood Pressure	No	Yes	
4.						Stroke	No	Yes	
5.						Epilepsy	No	Yes	
Husband or Wife						Insanity	No	Yes	
Son or Daughter 1.						Suicide	No	Yes	
2.									
3.									
4.									
5.									

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us in writing to do so.

PERSONAL HISTORY

ILLNESSES: Have you ever had the following:

Please encircle all answers	No	Yes	High or low blood pressure _____	No	Yes
Measles _____	No	Yes	Colitis or other bowel disease _____	No	Yes
German Measles _____	No	Yes	Hemorrhoids or any rectal disease _____	No	Yes
Mumps _____	No	Yes	Nervous Breakdown _____	No	Yes
Chicken Pox _____	No	Yes	Food, chemical or drug poisoning _____	No	Yes
Whooping Cough _____	No	Yes	Hay Fever or Asthma _____	No	Yes
Scarlet Fever or Scarlatina _____	No	Yes	Hives or Eczema _____	No	Yes
Diphtheria _____	No	Yes	Frequent infections or boils _____	No	Yes
Smallpox _____	No	Yes	AIDS _____	No	Yes
Pneumonia _____	No	Yes	Any other disease _____	No	Yes
Influenza _____	No	Yes	ALLERGIES: Are you allergic to		
Pleurisy _____	No	Yes	Penicillin or Sulfa _____	No	Yes
Rheumatic Fever or Heart Disease _____	No	Yes	Aspirin, Codeine or Morphine _____	No	Yes
Arthritis or Rheumatism _____	No	Yes	Mycins or other antibiotics _____	No	Yes
Any bone or joint disease _____	No	Yes	Merthiolate or Mercurochrome _____	No	Yes
Neuritis or Neuralgia _____	No	Yes	Any other drug _____	No	Yes
Bursitis, Sciatica or Lumbago _____	No	Yes	Any food s _____	No	Yes
Polio or Meningitis _____	No	Yes	Adhesive tape _____	No	Yes
Nephritis _____	No	Yes	Nail polish or other cosmetics _____	No	Yes
Gonorrhoea or Syphilis _____	No	Yes	Tetanus antitoxin or serums _____	No	Yes
Gallbladder Disease _____	No	Yes	INJURIES: Have you had any		
Anemia _____	No	Yes	Broken or cracked bones _____	No	Yes
Jaundice _____	No	Yes	Sprains _____	No	Yes
Bladder Disease _____	No	Yes	Lacerations _____	No	Yes
Epilepsy _____	No	Yes	Dislocations _____	No	Yes
Migraine Headaches _____	No	Yes	Concussion or head injury _____	No	Yes
Tuberculosis _____	No	Yes	Ever been knocked unconscious _____	No	Yes
Diabetes _____	No	Yes	WEIGHT: Now _____ One Year Ago _____		
Cancer _____	No	Yes	Maximum _____ When _____		

SURGERY: Have you had

Tonsillectomy _____	No	Yes
Appendectomy _____	No	Yes
Other operation _____	No	Yes
Type _____	Year _____	
Type _____	Year _____	
Type _____	Year _____	

Do you smoke: No Yes
 How many per day _____

Have you ever been advised to have any surgical operation which has not been done? No Yes

Have you been hospitalized for any illness: No Yes
 Give Details:

TRANSFUSIONS: Have you ever had
 Blood or plasma transfusion _____ No Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or severe headaches _____ No Yes
 Fainting spells _____ No Yes
 Dizziness on change of position _____ No Yes
 Unconscious spells _____ No Yes
 Blurred vision _____ No Yes
 Double vision _____ No Yes
 Spots before eyes _____ No Yes
 Infected eyes _____ No Yes
 Pain behind eyes _____ No Yes
 Any change in vision _____ No Yes
 Do you wear glasses _____ No Yes
 When were they last checked _____
 Earaches _____ No Yes
 Discharge from ears _____ No Yes
 Ringing in ears _____ No Yes
 Decrease in hearing _____ No Yes
 Recurrent nose bleeds _____ No Yes
 Recurrent head colds _____ No Yes
 Sinus trouble _____ No Yes
 Hay fever _____ No Yes
 Strange persistent odors _____ No Yes
 Strange taste or loss in taste _____ No Yes
 Persistent hoarseness _____ No Yes
 Difficulty swallowing _____ No Yes
 Enlarged glands _____ No Yes
 Recurrent sore throats _____ No Yes
 Recurrent sores in mouth _____ No Yes
 Soreness or bleeding of gums on brushing _____ No Yes
 Chest pain _____ No Yes
 Angina pectoris _____ No Yes
 Coughed up blood _____ No Yes
 Pain in arm(s) _____ No Yes
 Night sweats _____ No Yes
 Chronic or frequent cough _____ No Yes
 Chronic or frequent cough on laying down _____ No Yes
 How many bed pillows do you use? _____
 Shortness of breath on:
 Walking several blocks _____ No Yes
 One flight of stairs _____ No Yes
 On laying down _____ No Yes
 Purple lips or fingers _____ No Yes
 Palpitations or fluttering of heart _____ No Yes
 High blood pressure _____ No Yes
 Swelling of hands, feet or ankles _____ No Yes
 At what time of day _____
 Leg cramps on walking or at night _____ No Yes
 Enlarged veins in leg _____ No Yes
 Recurrent stomach pain _____ No Yes
 Belching or heartburn _____ No Yes
 Relieved by food or medication _____ No Yes
 Appetite – Good Fair Poor
 Nausea or vomiting _____ No Yes
 Vomited blood _____ No Yes
 Avoid some foods _____ No Yes
 What kinds _____
 Avoid spices _____ No Yes
 Abdominal cramping _____ No Yes
 Color of bowel movement _____
 Any blood in BM _____ No Yes
 Rectal pain with bowel movement _____ No Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Change in size, shape or texture of BM _____ No Yes
 Describe _____
 Pain on urinating _____ No Yes
 Difficulty in starting urination _____ No Yes
 Do you get up at night to urinate _____ No Yes
 How many times _____
 Urinate more than before _____ No Yes
 Urinate less than before _____ No Yes
 Any blood in urine _____ No Yes
 How many times per day do you urinate _____
 Full feeling of bladder, but only small amount
 of urination _____ No Yes
 Los urine on coughing or sneezing _____ No Yes

Discharge from penis _____ No Yes
 Recurrent back pains _____ No Yes
 Backaches _____ No Yes
 Joint pains _____ No Yes
 Swelling of any joints _____ No Yes
 Redness or heat of any joint _____ No Yes
 Tingling or weakness of hands or feet _____ No Yes
 Trembling of any extremity _____ No Yes
 Growth in neck or throat _____ No Yes
 Hot flashes _____ No Yes
 Tiredness without apparent reason _____ No Yes
 Brittleness of nails _____ No Yes
 Dryness of skin _____ No Yes
 Easy bruising _____ No Yes
 Inability to stand heat _____ No Yes
 Inability to stand cold _____ No Yes
 Change in hair texture _____ No Yes
 Change in skin texture _____ No Yes
 Any skin rash _____ No Yes

X-RAYS: Have you ever had x-rays of

Chest _____ No Yes
 Stomach or colon _____ No Yes
 Gall bladder _____ No Yes
 Extremities _____ No Yes
 Back _____ No Yes
 Teeth _____ No Yes
 Other _____ No Yes

EKG: Have you ever had an electrocardiogram _____ No Yes

IMMUNIZATIONS: Have you had

Smallpox vaccination within last 7 years _____ No Yes
 Tetanus shots (not antitoxin which last only 2 weeks) _____ No Yes
 Polio shots within last 2 years _____ No Yes

DRUGS:

Laxatives: never occ freq daily
 Vitamins: never occ freq daily
 Sedatives: never occ freq daily
 Tranquilizers: never occ freq daily
 Sleeping pills, etc: never occ freq daily
 Aspirin, etc: never occ freq daily
 Cortisone, ACTH: never occ freq daily
 Thyroid meds: never yes, in the past, none now
 daily now on _____ gr./day
 Appetite suppressants: never occ freq daily

Have you ever been treated for drug habits _____ No Yes
 Have you ever taken insulin or tablets for diabetes _____ No Yes
 Have you ever taken hormone tablets or injections _____ No Yes
SEX: Entirely satisfactory _____ No Yes

WOMEN ONLY – MENSTRUAL HISTORY

Age at onset _____
 Regular? Yes No Varies
 Cycle _____ days (from start to finish)
 Flow: Heavy Medium Light
 Number of pads or tampons used per period _____
 Any clots passed _____ No Yes
 Pains or cramps _____ No Yes
 Date of last period _____ No Yes
 Date of last pelvic exam _____ No Yes
 Date of last Pap Test _____
 Results Pos. Neg.
 Any discharge from vagina _____ No Yes
 If so, what color _____
 Amount _____
 Any itching of vaginal area _____ No Yes
 Do you take birth control pills _____ No Yes
 How long have you taken them _____
 Pregnancies:
 How many children born alive _____
 How many still births _____
 How many premature births _____
 How many Cesarean sections _____
 How many miscarriages _____
 Any complications with pregnancy _____ No Yes
 Please describe _____

Patient Information Form

Date of scheduled visit: ____/____/____

Today's Date: ____/____/____

NAME: _____

SS#: ____-____-____

Date of birth: ____/____/____

Age: _____

Your Occupation: _____

Email address: _____

Referral Information:

Reason for visit: _____

How did you hear about our program? _____

Were you referred by another patient? **Y** or **N**

OR

Referring doctor's name: _____ Phone (____)____-____ Fax (____)____-____

Address: _____
(street) (city) (state) (zip)

Is this the physician you see for routine Gynecologic care? (annual Pap smears, etc) **Y** or **N**

If no, who is your regular gynecologist? _____

Address: _____
(street) (city) (state) (zip)

Is there another physician (s) to whom you would like us to send a letter? **Y** or **N**

If yes, physician name: _____

Address: _____
(street) (city) (state) (zip)

Emergency Contact Information:

In case of emergency please contact: _____ Relationship: _____

Phone: (____)____-____ Beeper: (____)____-____ Cell Phone: (____)____-____

Address: _____
(street) (city) (state) (zip)

MEDICAL INFORMATION

NAME: _____ SS#: _____-____-_____

Years of current marriage (duration of relationship)..... _____

Number of marriages..... _____

Duration of infertility (months of trying w/o birth control)..... _____

Age of first menstrual period..... _____

Number of days bleeding during menstrual period..... _____

Number of days between menstrual periods..... ___ to ___
 (From the 1st day of bleeding to the next, 1st day of bleeding)

	<i>Circle One</i>	Comments
Do you have any symptoms prior to your menses?	Yes No	_____
Do you have painful menses (dysmenorrhea)?	Yes No	_____
Is intercourse painful?	Yes No	_____
Have you ever used an intrauterine device (IUD)?	Yes No	_____
Do you have a history of pelvic infection (PID)?	Yes No	_____
Did you mother take DES during her pregnancy?	Yes No	_____
Do you have discharge from your breasts (galactorrhea)?	Yes No	_____
Do you feel you experience excessive hair growth (hirsutism)?	Yes No	_____

PREGNANCY DATA: Please list **all** pregnancies

#	Date Pregnancy Delivered/ Ended	Pregnancy Outcome	Infertility Treatment? E.g., clomid, fertinex, IUI, IVF	# Months required to conceive	Sex M/F	Conceived with current partner?	Comments (weight, complications, etc.)

(Additional room at the end of the form)

Previous Testing: list any previous fertility testing, including dates and results if known.

Previous Treatment: list any previous fertility treatments, including dates and types.

Have you ever had a **hysterosalpinogram (hysteroogram, HSG)**? Indicate date and test results.

IVF History: Number of previous IVF/GIFT/ZIFT/TET cycles: _____. Please list information regarding any of these prior cycles. Please be as detailed as possible, including dates, locations, dosages of medication and outcomes of cycles.

#	Date	Location of program	Medication dosage	Peak estradiol	# of eggs	# GIFT'd	# Fertilized	Fertilization Method	# Transferred	Pregnancy

(Additional room at the end of the form)

Previous Surgery: Please list all surgeries, related to infertility or not

Date	Location of procedure	Procedure	Findings	Surgeon	Asst.

(Additional room at the end of the form)

Additional Information

Circle One

Circle One

Rubella Immunity...Date Tested ___/___/___ Immune Non-Immune Pap... Date tested ___/___/___ Normal? Yes No

Mycoplasma...Date tested ___/___/___ Positive Negative Blood Type... _____

Chlamydia...Date tested ___/___/___ Positive Negative Mammogram...Date tested ___/___/___

Normal? Yes No

Medical History: Do you have any medical problems unrelated to your infertility? Please check all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Overactive/Underactive Thyroid | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rubella (German measles) |
| <input type="checkbox"/> Frequent urinary tract infections | <input type="checkbox"/> Sexually Transmitted Diseases (syphilis, gonorrhea, herpes, genital warts) |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Illicit drug use | |

Please explain: _____

Family History: Do any diseases run in your family? Do any of your relatives suffer from a major illness? Please indicate the nature of the illness and family member.

	<i>Circle One</i>	Comments
Does anyone in your family have a history of breast cancer?	Yes No	_____
Does anyone in your family have a history of ovarian cancer?	Yes No	_____
Do you have any family history of birth defects?	Yes No	_____
Do you have any family history of recurrent pregnancy loss?	Yes No	_____
Have you ever suffered from an eating disorder?	Yes No	_____
Do you exercise? How frequently and what type?	Yes No	_____
Do you have any allergies to medication?	Yes No	_____
Do you smoke cigarettes? Cigarettes Per day _____	Yes No	_____
Do you drink alcohol? Per day _____	Yes No	_____
Do you take any medications regularly? Please list.	Yes No	_____
Have you been exposed to any toxins?	Yes No	_____
Do you use vaginal lubricant during intercourse?	Yes No	_____
Did your mother have a hysterectomy?	Yes No	Mother's age of menopause _____
How many times a month do you have intercourse? _____		

Have you ever used an ovulation predictor kit? What days of your cycle does it indicate ovulation? _____

How many cups of coffee or caffeinated beverages do you drink each day? _____

Are you on any special diets or nutritional supplements? If yes, please explain _____

Do you take multivitamin supplements? _____

Do you use any herbal remedies? _____

Do you take any over the counter medication? If yes, please explain _____

Genetic Screening: The following questions will help us determine if you are at increased risk for having a child with a genetic problem and if special screening is indicated.

Do you, or anyone in your family, have a history of: (check all that apply and indicate relationship to you)

- | | <i>Relationship to you</i> | | <i>Relationship to you</i> |
|--|----------------------------|--|----------------------------|
| <input type="checkbox"/> Thalassemia | _____ | <input type="checkbox"/> Muscular Dystrophy | _____ |
| <input type="checkbox"/> Neural Tube defect | _____ | <input type="checkbox"/> Cystic Fibrosis | _____ |
| <input type="checkbox"/> Down Syndrome | _____ | <input type="checkbox"/> Huntington's Chorea | _____ |
| <input type="checkbox"/> Tay Sachs | _____ | <input type="checkbox"/> Mental Retardation | _____ |
| <input type="checkbox"/> Hemophilia | _____ | <input type="checkbox"/> Sickle Cell Anemia | _____ |
| <input type="checkbox"/> Other inherited/chromosomal/genetic abnormalities | _____ | | |

Please Explain: _____

Ethnic Origin: This will help us identify risk factors for particular inherited diseases. (Please choose all that apply)

_____ White non-Hispanic _____ White Hispanic _____ Black non-Hispanic _____ Black Hispanic

_____ Asian or Pacific Islander non-Hispanic _____ Asian or Pacific Islander Hispanic

_____ Native American (American Indian including Aleut and Eskimo)

_____ French Canadian _____ Jewish Background

_____ Other: (please explain) _____

Do you use any recreational drugs? Yes No _____

Have you been exposed to any toxins? Yes No _____

Do you have any difficulties with erection? Yes No _____

Do you have any difficulties with ejaculation? Yes No _____

Are your genitals exposed to excessive heat? Yes No _____

Have you had any serious injuries to your genitals? Yes No _____

Have you had any infections of your penis, testicles or prostate? Yes No _____

Is there any history of birth defects in your family? Yes No _____

Do you have any allergies to medications? Yes No _____

Are you on any special diets or nutritional supplements? If yes, please explain: _____

Do you take multivitamin supplements? _____

Do you use any herbal remedies? _____

Do you take any over the counter medication? If yes, please explain _____

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|--|----------------------------|--|----------------------------|
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| <input type="checkbox"/> Neural Tube defect | _____ | <input type="checkbox"/> Cystic Fibrosis | _____ |
| <input type="checkbox"/> Down Syndrome | _____ | <input type="checkbox"/> Huntington's Chorea | _____ |
| <input type="checkbox"/> Tay Sachs | _____ | <input type="checkbox"/> Mental Retardation | _____ |
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White non-Hispanic White Hispanic Black non-Hispanic Black Hispanic

Asian or Pacific Islander non-Hispanic Asian or Pacific Islander Hispanic

Native American (American Indian including Aleut and Eskimo)

French Canadian Jewish Background

Other, please explain _____

Sex Selection Screening History; FEMALE

General Health

Do you **exercise** at least 3 times per week? N Y
Do you **drink** 64 ounces of water per day? N Y
Do you drink **caffeinated** beverages? N Y
Do you use **tobacco** (if so, how much per day? How many years?) N Y : _____ cigarettes/day _____ years
Do you consume **alcohol**? N Y _____ drinks/wk
Have you ever dealt with **depression**? N Y
Have you ever been **abused**? N Y
Do you feel ready for (another) pregnancy? N Y
Do you use **drugs** for other than prescribed indications? N Y
Have you ever tried to hurt yourself (**suicide**)? N Y
Do you currently feel **safe**? N Y
Using the list on the right, please circle any **medical conditions that run in your family**:
[Breast Cancer] [Ovarian Cancer]
[High Blood pressure] [High Cholesterol] [Heart Disease] [Stroke]
[Diabetes] [Thyroid disease]

Menstrual – Gyn History

Date of first day of your **last menses**?
Are your **menstrual periods regular**?
Do you have **heavy bleeding** with your menses?
Have you ever been advised you may have (circle): [uterine fibroids or scarring][endometrial polyps][a tight or weak cervix]
Is there a chance you could be currently **pregnant**?
How many days between your menstrual periods?
How many days do your menstrual periods last?
How many pads or tampons are soaked per day?

Pregnancies

How many **pregnancies** have you had?
How many children have you delivered: ____ **girls**: ____ **boys**: ____
How old are your children now: _____
What **type of deliveries** have you had: [Vaginal] [Cesarean]
Were any of your **pregnancies complicated**? [Diabetes] [High blood pressure]
Were any of your **deliveries complicated**? [Forceps or vacuum used] [Heavy bleeding]
(please circle any complications at right) [Baby was admitted to ICU]
Have you had any **abortions**? If so, how many abortions? ____ How many weeks along? ____
Have you had any **miscarriages**? If so, how many miscarriages? ____ How many weeks along? ____
Have you ever been told **NOT to become pregnant again**? YES NO If yes, REASON:

Contraception (Birth Control)

What type of **birth control** are you using now?
Very Effective Birth Control Methods: [Depo] [Birth control pill] [Norplant] [IUD] [Vasectomy] [Tubal]
Somewhat Effective Birth Control Methods: [Diaphragm] [Cervical Cap] [Condom] [Spermicidal gel or foam]
Not Very Effective Birth Control Methods: [Rhythm Method] [Withdrawal][No contraceptive]

Gender Balance In the Family

Of all of your **brothers' and sisters' children**, total number of: **BOYS** _____ **GIRLS** _____
Primary reason you are considering sex selection: Family balancing Sex linked disease Heir Other _____
Is there ANY male child anywhere in the family with the **SAME LAST NAME** as your partner? YES NO Is this important to you? YES NO

Sexually Transmitted Disease

Have you ever had a **sexually transmitted disease**? [Trichomonas] [Genital warts] [Genital Herpes] [HPV]
Have you ever had **Pelvic Inflammatory Disease**? [Chlamydia] [Gonorrhea] [Syphilis][Hepatitis A B C] [HIV]

Pap Smear

Have you ever had an **abnormal Pap Smear**? N Y What abnormality was found?
Have you had a **Colposcopy** procedure? N Y [Biopsy] [Freezing] [LEEP] [CONE]

Breast Exam

Have you ever had an **abnormal breast exam**? N Y What abnormality was found?
Have you had an abnormal **Mammogram**? N Y Do you do your own **self breast exams** each month? N Y

FEMALE GENETIC SCREENING



Name: _____ Age: _____

- | | YES | NO |
|--|-------|-------|
| 1. Will you be 35 years or older when you have children? | _____ | _____ |
| 2. Have you or your partner or anyone in your families ever had: | | |
| A. DOWN'S SYNDROM (MONGOLISM)? | _____ | _____ |
| B. SPINA BIFIDA OR MENINGOMYELOCELE? | _____ | _____ |
| C. HEMOPHILIA? | _____ | _____ |
| D. MUSCULAR DYSTROPHY? | _____ | _____ |
| E. CYSTIC FIBROSIS? | _____ | _____ |
| F. ANENCEPHALY-HYDROCEPHALY? | _____ | _____ |
| G. STILLBORN CHILD? | _____ | _____ |
| H. MENTAL RETARDATION? | _____ | _____ |
| I. SICKLE-CELL TRAIT/ANEMIA? | _____ | _____ |
| J. ARE YOU OR YOUR PARTNER JEWISH? | _____ | _____ |
| If yes, have you been screened for Tay-Sachs? | _____ | _____ |

If you have any specific concerns about genetic screening, please list them here: _____

OUR FINANCIAL POLICY
JEFFERY STEINBERG, M.D., INCORPORATED

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the doctor.

- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS.
- WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

Regarding Insurance

We may accept assignment of insurance benefits after your second visit *if* you can provide us a letter from your insurer indicating that you are fully covered for the planned treatment with a dollar amount satisfactory to cover your total estimated bill. In the absence of such a letter, we do require 100% of the bill to be paid at time of service. Any unpaid balance on an account is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do conditionally accept assignment of benefits, we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for automatically transferred to your credit card or the extended payment plan. Please be aware that some and perhaps all of the services provided may be non-covered services or considered unreasonable and unnecessary under some medical insurance plans.

Regarding insurance plans where we are participating providers, all pre-authorizations, co-pays and deductibles are due prior to treatment. Should a co-pay or deductible fail to be collected, the balance due will be billed to your credit card account. If services are provided without prior receipt by us of pre-authorization, the charges for such services are due at the time of services rendered. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

*I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ X _____ _____
Signature of Patient Signature of Patient (spouse) Date

**PAYMENT DEFINITION, EXPLANATION AND POLICY STATEMENT
FOR ASSISTED REPRODUCTIVE TECHNOLOGY (ART)
PROCEDURES (IVF, ICSI, GIFT, MESA, TET, PGD)**

Over the past several years' major advances in terms of increased pregnancy rates with the assisted reproductive technologies have been obtained by modifying and enhancing the techniques involved in the performances of these procedures.

At many centers, including our own, substantial gains in the achievement of pregnancy have been realized by customizing for each individual couple the many different chemical and biological preparations that are used in their ART procedure. This custom manufacturing and formulation process helps assure that the eggs and sperm obtained from each couple for use will be cultured in an environment customized specifically toward the needs of that couple. This has been repeatedly shown to optimize the chances of a successful outcome.

The laboratory procedures involved in this customization process are lengthy and detailed. Because there can be tremendous variability in the length of time required to adequately prepare for each SITUATION, our policy is to order the laboratory to begin preparatory work for a planned cycle upon receipt of initial ART payment from patients electing to undertake a procedure. The formulations prepared for you can be stored for a limited time; however, they cannot be used for anyone else.

It is important to understand that initial payments for ART procedures will be applied to work and procedures carried out on your behalf by the laboratory and clinical teams involved in your care long before your actual treatment cycle begins. This work takes place "behind the scenes." Although you may not see or realize the extent of the effort on your behalf, a great deal of the labor that has led to our impressive success rates occurs prior to the start of your actual "clinical" (office visits, ultrasounds, etc.) treatment. Your initial payments to us will be used to pay for these procedures.

The initial laboratory work carried out on your behalf is mandatory for participation in our program. Payments of such fees in advance will assure that the laboratory will be ready for your cycle at any time after the setup is complete. Should you elect to postpone or cancel a planned cycle at any time after payment for the initial set up work, there will be no subsequent recharge for another set up at a later time, however there will not be made available any refund for work already completed on your behalf. It is important to understand that the initial cycle payments will result in mandatory laboratory set up fees, which approximate 25%-50% of your total cycle costs. These fees must be considered non-refundable.

*Our signature below indicate that we have read and have had explained to our satisfaction the above policy related to payment and partial payment for ART cycles performed by Jeffrey Steinberg, MD, Incorporated including the clinical and laboratory staff.

X _____
Signature of Patient

X _____
Signature of Patient (spouse)

Date

**PATIENT AGREEMENT AND ASSIGNMENT OF
INSURANCE BENEFITS**

Re: (Patient) _____

Release of Information:

The undersigned, whether she/he signs as agent or patient, hereby authorizes Jeffrey M. Steinberg, M.D. to release or disclose any information acquired in the course of examination or treatment of the patient including her/his medical records to any person or entity which is or may be liable for all or a portion of Jeffrey M. Steinberg, M.D.'s charges including but not limited to insurance companies, health care service plans, or worker's compensation carriers. A photocopy of this form shall be deemed as valid as the original.

Signature: _____

(Patient/Parent/Guardian)

Financial Agreement:

The undersigned agrees, whether she/he signs as agent or as patient, that she/he hereby individually obligates herself/himself to pay to the account of Jeffrey M. Steinberg, M.D. all amounts for professional services not covered or paid by insurance or other third party reimbursement for the same. The undersigned further agrees to immediately, upon receipt of the same, endorse or cause to be endorsed and delivered to Jeffrey M. Steinberg, M.D. all payments made by an insurance company or any other third party for the benefit of the patient of the undersigned as reimbursement for professional services provided by Jeffrey M. Steinberg, M.D.

Assignment of Insurance Benefits:

The undersigned authorizes, whether she/he as agent or as patient direct payment to Jeffrey M. Steinberg, M.D. of any insurance benefits otherwise payable to the undersigned for professional service charges of Jeffrey M. Steinberg, M.D. It is agreed that payment to Jeffrey M. Steinberg, M.D. pursuant to this authorization, by an insurance company shall discharge said insurance of any and all obligation under a policy to the extent of such payment. It is understood by the undersigned that she/he is financially responsible for any and all charges not covered by this assignment.

Attorney's Fees:

Should this account be referred to an attorney for collection or a litigation brought to enforce its provisions, the undersigned shall pay all reasonable attorney's fees and collection expenses in addition to all other relief. All delinquent accounts (>60 days from date of service) shall bear interest at the legal rate.

*The undersigned certifies that she/he has read the foregoing, receiving a copy thereof, and is the patient, or duly authorized by the patient as patient's general agent to execute the above and accept its terms.

Signature: _____

(Patient/Parent/Guardian)

Date: _____