



The Fertility Center  
of Las Vegas

**Bruce S. Shapiro, M.D., FACOG**  
Sub-specialty Board Certified in  
Reproductive Endocrinology & Infertility  
Founder / Medical Doctor

**Said T. Daneshmand, M.D., FACOG**  
Sub-specialty Board Certified in  
Reproductive Endocrinology & Infertility

## WELCOME TO OUR OFFICE

### Please Read Me First!

We are pleased that you chose The Fertility Center of Las Vegas to provide your medical care. We have set personal and professional goals with regard to making each visit to our office a pleasant experience.

Your appointment with:

Dr. Shapiro       Dr. Daneshmand

Will be on \_\_\_\_\_ at \_\_\_\_\_ AM / PM

You are scheduled at our:

- Sahara location - 8851 W. Sahara Avenue, Suite 100, LV, NV 89117
- Green Valley Location - 2769 Sunridge Heights Pkwy, Henderson, NV 89052

### The next new patient seminar will be held at:

- Sahara location - 8851 W. Sahara Avenue, Suite 100, LV, NV 89117
- Green Valley Location - 2769 Sunridge Heights Pkwy, Henderson, NV 89052

Because your first visit with us will be the most informative, we are asking that you follow these instructions.

1. Complete the enclosed paperwork, including the records release form, and return them to our office within 48 hours of receiving the packet. If you feel the paperwork will not reach us in time for your appointment, you may fax it to 702.228.2678.
2. Include enlarged copies of your driver's license and medical insurance cards (front and back of cards for both partners).

For patients without insurance coverage or for those whom insurance does not cover infertility, the office visit cost of \$287.00 will be payable at time of service. If an authorization is required for your HMO or POS insurance for this visit, you will need to ask your primary care physician to submit the authorization request. To those patients who do not have fertility benefits we offer a variety of financial options to serve you. Please contact your Billing Representative for more details. (see page 3 for more information).

Due to the nature of the services we provide, we would greatly appreciate if you could arrange for childcare when attending the patient seminar or for your office visits.

Appointment cancellation and rescheduling should be done five (5) business days before your appointment to avoid a fee of \$50.

If you have questions, I can be reached at 702.254.1777 or Shelley@fertilitycenterlv.com or you may contact my assistant Chelsea Pohlman at chelsea@fertilitycenterlv.com

Sincerely,

Shelley Kreutzer  
Administrator



The Fertility Center  
of Las Vegas

## Welcome To The Fertility Center of Las Vegas

### Office Goal

The Fertility Center staff operates as a team to provide quality health care to our patients. This letter is designed to answer questions that usually arise regarding your medical care. Our goal is to provide you with the best healthcare possible; therefore, we have two locations to serve you. Our western location located at 8851 W. Sahara and our Green Valley location located at 2769 Sunridge Heights Parkway.

### Office Hours

West Sahara: Regular office hours are 6:30 AM to 5:00 PM, Monday through Friday. Daily blood draws are done between the hours of 6:30 AM and 8:30 AM daily, including weekends. Patients are routinely seen between 7:00 AM and 11:00 AM and between 2:00 PM and 4:00 PM.

Green Valley: Regular office hours are 6:30 AM to 5:30 PM Monday through Friday. Daily blood draws are done from 6:30 AM - 8:30 AM Monday through Friday. Appointments may be scheduled from 7:30 AM - 5:30 PM. Every effort is made to see you at your scheduled appointment time. However, circumstances do arise which require the Doctor to spend a longer amount of time with a patient. Please be assured that when you are with the Doctor, he will give you the same individual attention. You will be kept informed of how the schedule is running.

### Telephone Calls

Our telephone hours are from 8:00 AM to 5:00 PM. Patient telephone calls and test results are reviewed by the medical staff daily. Return calls are made between 3:00 PM and 5:00 PM. Please make sure we have your current telephone number where you can be reached during these hours. Emergency situations will be evaluated immediately.

The Physicians are available after regular office hours and on the weekends. They can be reached by calling the office. If the office is closed the answering service will take your message and telephone number and contact the Physician on call for you. Please make sure you give the answering service the telephone number you will be at for the next couple of hours, as the Physician on call may not be available to call you back immediately.

If you ever feel the need and would like to speak with your Physician, do not hesitate to call him. He is always available for you. You may also reach him by email at [drshapiro@fertilitycenterlv.com](mailto:drshapiro@fertilitycenterlv.com) or [drdaneshmand@fertilitycenterlv.com](mailto:drdaneshmand@fertilitycenterlv.com)

### Ancillary Staff

The Fertility Center employs registered nurses, physicians assistants and ultrasonographers who assist in the care of their patients. You may request a specific caregiver or a specific time for your visit. Please remember that every effort will be made to accommodate you.



The Fertility Center  
of Las Vegas

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## INFERTILITY HISTORY FORM

*Important: Please complete this form and mail it prior to your scheduled appointment. If there is not enough time for us to receive it, please bring it to your appointment 45 minutes early.*

*This form was developed by The American Society of Reproductive Medicine to assist physicians in obtaining a complete infertility history.*

### PART I: CONTACT INFORMATION

Name \_\_\_\_\_ SS # \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Occupation \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Indicate which number to call or leave message.

Home \_\_\_\_\_  Work \_\_\_\_\_  Cell \_\_\_\_\_

Are you married? \_\_\_\_\_ Divorced? \_\_\_\_\_ Other? \_\_\_\_\_

#### INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Telephone \_\_\_\_\_

Insured \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ Plan \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Telephone \_\_\_\_\_

Insured \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ Plan \_\_\_\_\_

#### SPOUSES / MALE PARTNER'S

Name \_\_\_\_\_ SS # \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Occupation \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Indicate which number to call or leave message.

Home \_\_\_\_\_  Work \_\_\_\_\_  Cell \_\_\_\_\_

#### INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Telephone \_\_\_\_\_

Insured \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ Plan \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Telephone \_\_\_\_\_

Insured \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ Plan \_\_\_\_\_

#### HOW DID YOU HEAR ABOUT US?

Physician, Name \_\_\_\_\_  Existing Patient, Name: \_\_\_\_\_

TV, Which? \_\_\_\_\_  Radio, Which? \_\_\_\_\_

Newspaper, Which? \_\_\_\_\_  Internet, Which Site? \_\_\_\_\_

Friend \_\_\_\_\_  Insurance, Which? \_\_\_\_\_

Other, please specify: \_\_\_\_\_

Who is your OB/GYN? \_\_\_\_\_ Phone \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_ Phone \_\_\_\_\_



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Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Part II: FEMALE MEDICAL HISTORY AND INFORMATION

Reasons for your visit:

Infertility Evaluation? \_\_\_\_\_

Previous tubal sterilization? \_\_\_\_\_

Other? \_\_\_\_\_

What are your expectations for this visit?

\_\_\_\_\_

What questions would you like answered at this visit?

\_\_\_\_\_

Do you have any personal, ethical, or religious objections to any of the treatments such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.? Yes \_\_\_ No \_\_\_

How many months have you been having intercourse without using any kind of birth control? \_\_\_\_\_

### PREGNANCY SUMMARY

Total number of all pregnancies \_\_\_\_\_ Number of miscarriages \_\_\_\_\_

Number of ectopic pregnancies \_\_\_\_\_ Number of abortions \_\_\_\_\_

Number of full term deliveries \_\_\_\_\_ Number of pre-term \_\_\_\_\_ (<37 weeks)

Of these, how many were live births? \_\_\_\_\_

Of these, how many were stillborn? \_\_\_\_\_

Any pregnancies with birth defects? \_\_\_\_\_

If yes, explain \_\_\_\_\_

Date pregnancy ended or delivered	Months to conception	Treatments to conceive	Delivery type	Current partner?
1				
2				
3				
4				
5				

### MENSTRUAL HISTORY

Menstrual cycle pattern (check all that apply)

No periods \_\_\_\_\_ Regular \_\_\_\_\_ Irregular \_\_\_\_\_

Spotting before \_\_\_\_\_ Heavy \_\_\_\_\_ Light \_\_\_\_\_ Bleeding before \_\_\_\_\_

Age of 1st menstrual period \_\_\_\_\_ How many periods do you have per year? \_\_\_\_\_

Number of days between periods \_\_\_\_\_ Days of bleeding \_\_\_\_\_

Dates of the 1st day of your last two periods \_\_\_ / \_\_\_ / \_\_\_ : \_\_\_ / \_\_\_ / \_\_\_

Do you need medication to start a period? \_\_\_\_\_ What type? \_\_\_\_\_

If you do not have periods, at which age did you stop having them? \_\_\_\_\_

Do you have severe pain or cramping with your periods? \_\_\_\_\_

Never \_\_\_\_\_ Always \_\_\_\_\_ Sometimes \_\_\_\_\_



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Name: \_\_\_\_\_

Date: \_\_\_\_\_

## CONTRACEPTIVE HISTORY

Check all that apply	Dates of use	Any complications?	
		Yes	No
_____	Condoms _____	_____	_____
_____	Diaphragm _____	_____	_____
_____	IUD _____	_____	_____
_____	Pills _____	_____	_____
_____	DepoProvera _____	_____	_____
_____	Skin Patch _____	_____	_____
_____	Foam or Jelly _____	_____	_____
_____	Tubal Sterilization Procedure _____	Date _____	

Did your mother take DES when she was pregnant with you?  
 Yes \_\_\_\_\_ No \_\_\_\_\_ Don't know \_\_\_\_\_

## SEXUAL HISTORY

How many times do you have intercourse a week? \_\_\_\_\_ None \_\_\_\_\_ N/A \_\_\_\_\_

Have you ever used over-the-counter ovulation kits to time intercourse? \_\_\_\_\_

Do you have pain with intercourse? \_\_\_\_\_

Do you use lubricants (K - Y Jelly, etc.) during intercourse? \_\_\_\_\_ Which one? \_\_\_\_\_

Have you had any of the following sexually transmitted diseases or pelvic infections?

Chlamydia _____	Gonorrhea _____	Herpes _____
Syphilis _____	HIV/AIDS _____	Hepatitis _____
Genital Warts _____	Other _____	

## PAP SMEAR HISTORY

When was your last pap smear? \_\_\_\_/\_\_\_\_/\_\_\_\_ Normal? \_\_\_\_\_ Abnormal? \_\_\_\_\_

When was your last abnormal pap smear? \_\_\_\_/\_\_\_\_/\_\_\_\_ N/A \_\_\_\_\_

Have you undergone any procedures as a result of an abnormal pap smear?  
 Yes? \_\_\_\_\_ No? \_\_\_\_\_

If yes, check all that apply:

LEEP _____	Colposcopy _____	Cryosurgery _____
Laser Treatment _____	Conization _____	

## BREAST SCREENING HISTORY

Have you ever had a mammogram? Yes \_\_\_\_\_ Date \_\_\_\_\_ No \_\_\_\_\_

Result: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

If abnormal, please explain the results: \_\_\_\_\_

Do you perform breast self exams? Yes \_\_\_\_\_ No \_\_\_\_\_



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Name: \_\_\_\_\_

Date: \_\_\_\_\_

### MEDICAL HISTORY

Are you allergic to any medications? No \_\_\_\_\_ Yes \_\_\_\_\_  
Please list and describe reactions: \_\_\_\_\_

Are you allergic to any foods? No \_\_\_\_\_ Yes \_\_\_\_\_  
Please list and describe reactions: \_\_\_\_\_

List any medications you are currently taking, including over-the-counter medications:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take any herbal medicines/vitamins or health food store supplements?  
No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please list \_\_\_\_\_

Do you have any medical problems? No \_\_\_\_\_ Yes \_\_\_\_\_  
Please list type, dates and treatments: \_\_\_\_\_

Did you have either of these childhood illnesses?  
Chickenpox (Varicella) \_\_\_\_\_ German Measles (Rubella) \_\_\_\_\_ Don't Know \_\_\_\_\_  
Other childhood diseases: \_\_\_\_\_

### VACCINATIONS

	No	Yes	Dates	Don't Know
Chickenpox (Varicella)	_____	_____	_____	_____
MMR-Measles, Mumps, and Rubella	_____	_____	_____	_____
BCG (Tuberculosis)	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____
Polio	_____	_____	_____	_____
Hepatitis A	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____
Influenza	_____	_____	_____	_____

### SOCIAL HISTORY

How many caffeinated beverages (coffee, tea, soda) do you drink a day?  
Do you smoke cigarettes? No \_\_\_\_\_ Yes \_\_\_\_\_ How many/day? \_\_\_\_\_ Years? \_\_\_\_\_  
Quit \_\_\_\_\_ When? \_\_\_\_\_  
Do you drink alcohol? No \_\_\_\_\_ Yes \_\_\_\_\_  
Number per week: \_\_\_\_\_ Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor \_\_\_\_\_  
Do you use any illegal and / or unprescribed drug(s)?  
No \_\_\_\_\_ Yes \_\_\_\_\_ Describe \_\_\_\_\_  
Do you exercise? No \_\_\_\_\_ Yes \_\_\_\_\_ Describe \_\_\_\_\_  
Are you aware of any radiation exposures other than x-rays?  
No \_\_\_\_\_ Yes \_\_\_\_\_ Describe \_\_\_\_\_



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## PHYSICAL SYMPTOMS

### GENERAL:

- Recent weight gain
- Recent weight loss
- Anorexia/Bulimia
- Lack of energy
- Fever/Chills
- Other: \_\_\_\_\_
- None:

### ENDOCRINE/HORMONAL:

- Diabetes
- Thyroid gland prob.
- Rapid weight loss/gain
- Excessive hunger
- Excessive thirst
- Always hot
- Always cold
- Other: \_\_\_\_\_

### GASTROINTESTINAL

- Nausea/Vomiting
- Hepatitis
- Blood in stools
- Irritable bowel syn.
- Colitis
- Ulcers
- Constipation
- Other: \_\_\_\_\_

### MUSCOLOSKELETAL

- Unusual weakness
- Decreased energy
- Rheumatoid Arthritis
- Lupus Erythematosus
- Myasthenia gravis
- Other: \_\_\_\_\_

### MENTAL HEALTH PROBLEMS

- Depression

### EYES/EARS, NOSE, THROAT: RESPIRATORY:

- Dizziness
- Nasal congestion
- Headaches
- Blurred Vision
- Hearing Loss
- Loss of smell
- Ringing ears
- Other: \_\_\_\_\_
- Shortness of breath
- Asthma
- Pneumonia
- Bloody Cough
- Bronchitis
- Tuberculosis
- Other: \_\_\_\_\_

### BREASTS:

- Discharge (type)
- Lumps
- Pain
- Cancer
- Abnormal mammogram
- Reduction
- Implants \_\_\_silicone \_\_\_saline
- Other: \_\_\_\_\_

### GENITO-URINARY

- Bladder infections
- Kidney infections
- Vaginal infections
- Frequent urination
- Herpes
- Leaking urine
- Other: \_\_\_\_\_

### HEMATOLOGIC

- Blood clotting disorder
- Sickle cell anemia
- Thrombophlebitis
- Easy Bruising
- Swollen glands
- Blood transfusions
- Date/reason: \_\_\_\_\_
- \_\_\_\_\_

- Schizophrenia

### NEUROLOGICAL PROBLEMS

- Weakness/Loss of balance
- Seizures/Epilepsy
- Headaches
- Migraine headaches
- Numbness
- Memory Loss
- Other: \_\_\_\_\_

### SKIN/EXTREMITIES

- Unexplained rash/inflammation
- Acne
- Skin cancer
- Moles changing in appearance
- Excess hair growth
- Other: \_\_\_\_\_

### CARDIOVASCULAR

- Heart palpitations
- Chest pain     Heart Attack
- Stroke         Murmurs
- High blood pressures
- Rheumatic fever
- Mitral valve prolapsed (do you need antibiotics before dental procedures?  Yes  No
- Anxiety Disorder



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Name: \_\_\_\_\_

Date: \_\_\_\_\_

## FAMILY HISTORY

	<i>Living</i>	<i>Age</i>	<i>Age at death/Cause of death</i>	
Mother	Yes _____	Age _____	_____	_____
Father	Yes _____	Age _____	_____	_____
Brother(s)	Yes _____	Age _____	_____	_____
Sister(s)	Yes _____	Age _____	_____	_____
Maternal Grandmother	Yes _____	Age _____	_____	_____
Maternal Grandfather	Yes _____	Age _____	_____	_____
Paternal Grandmother	Yes _____	Age _____	_____	_____
Paternal Grandfather	Yes _____	Age _____	_____	_____

### DISORDERS IN YOUR FAMILY

	<i>Yes</i>	<i>Relationship to you</i>	<i>No</i>	<i>Don't Know</i>
Breast Cancer	Yes _____	_____	No _____	Don't Know _____
Ovarian Cancer	Yes _____	_____	No _____	Don't Know _____
Colon Cancer	Yes _____	_____	No _____	Don't Know _____
Other Cancer	Yes _____	_____	No _____	Don't Know _____
Diabetes	Yes _____	_____	No _____	Don't Know _____
Thyroid Problems	Yes _____	_____	No _____	Don't Know _____
Heart Disease	Yes _____	_____	No _____	Don't Know _____
Blood Clots	Yes _____	_____	No _____	Don't Know _____
Obesity	Yes _____	_____	No _____	Don't Know _____
Psychiatric Problems	Yes _____	_____	No _____	Don't Know _____
Tuberculosis	Yes _____	_____	No _____	Don't Know _____
Endometriosis	Yes _____	_____	No _____	Don't Know _____
Infertility	Yes _____	_____	No _____	Don't Know _____
Menopause before age 40	Yes _____	_____	No _____	Don't Know _____
Birth Defects	Yes _____	_____	No _____	Don't Know _____
Cystic Fibrosis	Yes _____	_____	No _____	Don't Know _____
Tay-Sachs Disease	Yes _____	_____	No _____	Don't Know _____
Gaucher Disease	Yes _____	_____	No _____	Don't Know _____
Niemann-Pick Disease	Yes _____	_____	No _____	Don't Know _____
Muscular Dystrophy	Yes _____	_____	No _____	Don't Know _____
Neurologic (brain/spine)	Yes _____	_____	No _____	Don't Know _____
Neural Tube Defects	Yes _____	_____	No _____	Don't Know _____
Bone/Skeletal Defects	Yes _____	_____	No _____	Don't Know _____
Dwarfism	Yes _____	_____	No _____	Don't Know _____
Polycystic Kidney Disease	Yes _____	_____	No _____	Don't Know _____
Heart Defect from Birth	Yes _____	_____	No _____	Don't Know _____
Down Syndrome	Yes _____	_____	No _____	Don't Know _____
Other chromosome defect	Yes _____	_____	No _____	Don't Know _____
Blood Disorders	Yes _____	_____	No _____	Don't Know _____
Hemochromatosis	Yes _____	_____	No _____	Don't Know _____
Other:	Yes _____	_____	No _____	Don't Know _____

### WHAT IS YOUR ANCESTRY?

- |                         |                              |
|-------------------------|------------------------------|
| _____ African American  | _____ American Indian/Native |
| _____ Ashkenasi Jewish  | _____ Asian-American         |
| _____ French Canadian   | _____ Caucasian              |
| _____ Eastern European  | _____ Hispanic/Caribbean     |
| _____ Northern European | _____ Southern European      |
| _____ Other: _____      |                              |

Would you like to be screened for: *(check if yes)*

- |                         |                          |
|-------------------------|--------------------------|
| _____ Cystic Fibrosis   | _____ Sickle Cell Anemia |
| _____ Tay-Sachs Disease | _____ Thalasemia         |



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## SURGICAL HISTORY

Have you had any surgeries? No \_\_\_\_\_ Yes \_\_\_\_\_

List all surgeries in chronological order:

Year	Reason	Type	Findings
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Did you have any anesthesia problems? No \_\_\_\_\_ Yes \_\_\_\_\_

Describe: \_\_\_\_\_

## PRIOR INFERTILITY TESTING AND TREATMENT

Have you had prior infertility testing or treatment elsewhere? No \_\_\_\_\_ Yes \_\_\_\_\_

### PRIOR TESTS

(check all that apply)

	Date	Results
_____ Basal body temperature chart	_____	_____
_____ Thyroid Test	_____	_____
_____ Day 3 Blood test for FSH level	_____	_____
_____ Hysterosalpingogram (HSG)	_____	_____
_____ Hysteroscopy	_____	_____
_____ Progesterone Blood Test	_____	_____
_____ Prolactin Blood Test	_____	_____
_____ Clomid Challenge Test	_____	_____

### PRIOR TREATMENT (check all that apply)

	No. of cycles	Dates (mo/yr)	Outcome
_____ Intrauterine insemination	_____	From: ___/___/___ To: ___/___/___	_____
_____ Clomiphene citrate with timed intercourse no. of tabs/day _____	_____	From: ___/___/___ To: ___/___/___	_____
_____ Clomiphene citrate with insemination no. of tabs/day _____	_____	From: ___/___/___ To: ___/___/___	_____
_____ Daily fertility drug injections with insemination no. of tabs/day _____	_____	From: ___/___/___ To: ___/___/___	_____
_____ Completed IVF cycles			
1. # eggs _____ # transferred _____ # frozen _____		___/___	_____
2. # eggs _____ # transferred _____ # frozen _____		___/___	_____
3. # eggs _____ # transferred _____ # frozen _____		___/___	_____
4. # eggs _____ # transferred _____ # frozen _____		___/___	_____
_____ Frozen embryo transfers			
1. # embryos transferred _____		___/___	_____
2. # embryos transferred _____		___/___	_____
3. # embryos transferred _____		___/___	_____
4. # embryos transferred _____		___/___	_____

\_\_\_\_\_ Cancelled in-vitro fertilization attempts

Any other prior treatments (describe) \_\_\_\_\_

Additional information/complications \_\_\_\_\_



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Name: \_\_\_\_\_

Date: \_\_\_\_\_

## MALE MEDICAL HISTORY AND INFORMATION

Complete with your male partner if applicable.

YES

NO

Have you been evaluated by a urologist? .....

Have you previously conceived with another woman? .....

If yes, number of times \_\_\_\_\_

If no, was birth control used? .....

Have you had a semen analysis? .....

Do you have difficulty with erections? .....

Do you have retrograde ejaculation of sperm into the bladder? .....

Have you had any of the following sexually transmitted diseases? .....

Chlamydia .....

Syphilis .....

Gonorrhea .....

HIV/AIDS .....

Herpes .....

Hepatitis .....

Genital warts .....

Other .....

Have you had a history of undescended testicles? .....

Do you have scrotal or testicular pain? .....

Did you have the mumps after puberty? .....

Have you had prior injury to your testicles requiring hospitalization? .....

Have you been diagnosed with any of the following? .....

Diabetes Mellitus .....

Multiple Sclerosis .....

Prostatic Infections .....

High Blood Pressure .....

If yes, any medications: \_\_\_\_\_

Cancer .....

Other neurologic problems .....

Urinary infections .....

Have you had any fever in the last 3 months? .....

Have you had a vasectomy? .....

If yes, have you had a vasectomy reversal? Date: \_\_\_ / \_\_\_ / \_\_\_

Have you had surgery for varicocele repair? .....

Have you had hernia surgery? .....

Did you undergo any bladder or penis surgery as a child? .....

Are you exposed to prolonged heat in the workplace? .....

Are you exposed to any radiation or harmful

chemicals in the workplace? .....

Have you had chemotherapy for cancer? .....

Are you allergic to any medications? .....

List: \_\_\_\_\_

Do you use hot tubs regularly? .....

Have any of your family members had trouble conceiving a child? .....

Did your mother take DES during pregnancy to prevent miscarriage? .....

Do you smoke cigarettes? \_\_\_\_\_

If yes, how many/day \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcohol? .....

Beer? #/week \_\_\_\_\_ Wine? #/week \_\_\_\_\_ Liquor? #/week \_\_\_\_\_

Do you use any illegal and / or unprescribed drug(s)? .....



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Name: \_\_\_\_\_

Date: \_\_\_\_\_

## MALE MEDICAL HISTORY (continued)

### DISORDERS IN YOUR FAMILY

	Yes _____	Relationship to you _____	No _____	Don't Know _____
Breast Cancer	Yes _____	_____	No _____	Don't Know _____
Ovarian Cancer	Yes _____	_____	No _____	Don't Know _____
Colon Cancer	Yes _____	_____	No _____	Don't Know _____
Other Cancer	Yes _____	_____	No _____	Don't Know _____
Diabetes	Yes _____	_____	No _____	Don't Know _____
Thyroid Problems	Yes _____	_____	No _____	Don't Know _____
Heart Disease	Yes _____	_____	No _____	Don't Know _____
Blood Clots	Yes _____	_____	No _____	Don't Know _____
Obesity	Yes _____	_____	No _____	Don't Know _____
Psychiatric Problems	Yes _____	_____	No _____	Don't Know _____
Tuberculosis	Yes _____	_____	No _____	Don't Know _____
Endometriosis	Yes _____	_____	No _____	Don't Know _____
Infertility	Yes _____	_____	No _____	Don't Know _____
Menopause before age 40	Yes _____	_____	No _____	Don't Know _____
Birth Defects	Yes _____	_____	No _____	Don't Know _____
Cystic Fibrosis	Yes _____	_____	No _____	Don't Know _____
Tay-Sachs Disease	Yes _____	_____	No _____	Don't Know _____
Gaucher Disease	Yes _____	_____	No _____	Don't Know _____
Niemann-Pick Disease	Yes _____	_____	No _____	Don't Know _____
Muscular Dystrophy	Yes _____	_____	No _____	Don't Know _____
Neurologic (brain/spine)	Yes _____	_____	No _____	Don't Know _____
Neural Tube Defects	Yes _____	_____	No _____	Don't Know _____
Bone/Skeletal Defects	Yes _____	_____	No _____	Don't Know _____
Dwarfism	Yes _____	_____	No _____	Don't Know _____
Polycystic Kidney Disease	Yes _____	_____	No _____	Don't Know _____
Heart Defect from Birth	Yes _____	_____	No _____	Don't Know _____
Down Syndrome	Yes _____	_____	No _____	Don't Know _____
Other chromosome defect	Yes _____	_____	No _____	Don't Know _____
Blood Disorders	Yes _____	_____	No _____	Don't Know _____
Hemochromatosis	Yes _____	_____	No _____	Don't Know _____
Other:	Yes _____	_____	No _____	Don't Know _____

### WHAT IS YOUR ANCESTRY?

<input type="checkbox"/> African American	<input type="checkbox"/> American Indian/Native
<input type="checkbox"/> Ashkenasi Jewish	<input type="checkbox"/> Asian-American
<input type="checkbox"/> French Canadian	<input type="checkbox"/> Caucasian
<input type="checkbox"/> Eastern European	<input type="checkbox"/> Hispanic/Caribbean
<input type="checkbox"/> Northern European	<input type="checkbox"/> Southern European
<input type="checkbox"/> Other: _____	

Would you like to be screened for: (check if yes)

<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Tay-Sachs Disease	<input type="checkbox"/> Thalasemia

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_





The Fertility Center  
of Las Vegas

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT CONTACT INFORMATION AND CONSENT

There are many instances that we will need to call you with test results or appointment information. We will identify ourselves by name and "from his or her Dr.'s office". We would like your permission on the following:

*Please circle your answer*

May we call you at home? Yes No N/A

Home phone # \_\_\_\_\_

When we call you at home, may we leave a message on an answering machine or voice mail? Yes No N/A

May we call you at work? Yes No N/A

Work phone # \_\_\_\_\_

When we call you at work, may we leave a message on an answering machine or voice mail? Yes No N/A

May we call your cell phone? Yes No N/A

Cell phone # \_\_\_\_\_

When we call your cell phone, may we leave a message on an answering machine or voice mail? Yes No N/A

When we call your cell phone, may we leave a message with the person that answers the phone if it is not you? Yes No N/A

May we call your pager? Yes No N/A

Pager # \_\_\_\_\_

If we need to fax or mail your medical records anywhere, we require a written records release form signed by you. A separate form is required for you and your spouse.

Are there any other privacy issues you would like to inform us of?

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\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date



The Fertility Center  
of Las Vegas

## OPT-IN NOTICE

The Fertility Center of Las Vegas regularly communicates with patients on all issues related to infertility and reproductive health. If you would like to receive regular communiqués, please indicate your preferences below.

### OUR MAILING LIST IS NEVER SOLD AND WE DO NOT SEND SPAM.

YES! Please subscribe me to:

I prefer to be contacted via:

- Newsletters
- Promotions & Special Offers
- Clinical Trial & Research Updates
- Special Events
- RSS Feeds for podcasts/webcasts
- ALL OF THE ABOVE

- Email
- US Post (please list below)
- Foreign Post (allow 6-8 weeks  
for delivery)

Name \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Signature: \_\_\_\_\_



The Fertility Center  
of Las Vegas

## BILLING / FINANCIAL POLICIES

Every patient is assigned a billing representative at The Fertility Center of Las Vegas. Our patient's are assigned by their last name. If your name begins with:

A-L Your billing representative is Jennifer Cavanaugh - [jennifer@fertilitycenterlv.com](mailto:jennifer@fertilitycenterlv.com)

M-Z Your billing representative is Crystal Rosburg - [crystal@fertilitycenterlv.com](mailto:crystal@fertilitycenterlv.com)

All benefits and authorizations are completed by Tani Alfazak - [tani@fertilitycenterlv.com](mailto:tani@fertilitycenterlv.com)

Your billing staff will do the following for you:

- Verify your benefits prior to your first appointment
- Pre-authorize on any procedures that your insurance company requires.
- Answer any questions regarding insurance or your account.

The billing supervisor is Jennifer Cavanaugh - [jennifer@fertilitycenterlv.com](mailto:jennifer@fertilitycenterlv.com)

Our office will verify your insurance prior to your first visit. The benefits quoted to The Fertility Center of Las Vegas are not a guarantee of payment. Understand that ultimately it is the patient's responsibility to know his/her own insurance coverage. If you dispute your benefit coverage in any way, please contact your insurance company. If you receive different benefit information from your insurance, have your insurance company give your representative a call or request this in writing.

\_\_\_\_\_  
Initials

Your billing representatives will obtain all authorizations required by your insurance. Please be advised if your insurance requires our office to obtain authorization or referral before services are rendered, please allow at least 72 hours to obtain this information for you. If there is a problem in obtaining this for you, you will be notified before the time of service. However, even though our office has obtained prior authorization for any services performed in our office, this is not a guarantee of benefits or payment to our facility. Therefore, if you do not have the benefits for the services you will be responsible for all charges incurred on that date of service. If you have the benefit, our facility will make every possible effort to get the services paid for you.

\_\_\_\_\_  
Initials

We must emphasize that payments are due before services are rendered, unless prior arrangements have been made with your billing representative. We realize that financial problems do arise. If this happens, please contact us promptly if you need assistance in the management of your account. Please be advised that a new treatment cycle cannot be initiated until any previous account balances have been paid in full. Therefore, payment is expected at the time of your visit. For your convenience, we do accept MasterCard, Visa, Discover and American Express.

\_\_\_\_\_  
Initials



The Fertility Center  
of Las Vegas

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Your billing representative will be happy to answer any of your questions or concerns. Due to the fact that we give personalized attention to each patient, there may be times you must leave a message. We will make every attempt to return your call promptly.

\_\_\_\_\_  
Initials

**Authorization to Pay Benefits and Financial Responsibility**

*Patient Name: (please print)* \_\_\_\_\_

I hereby authorize payment of medical benefits to The Fertility Center of Las Vegas for services rendered. I also authorize the Physicians to release any information in the course of my examination or treatment. The assignment will remain in effect, until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

\_\_\_\_\_  
*Signature of Patient or Responsible Party*

\_\_\_\_\_  
*Date*

I, \_\_\_\_\_ hereby agree to be financially responsible for all charges incurred, regardless of insurance coverage. In the event my account is referred to a collection service due to non-payment, I agree to pay collection/legal fees that are incurred.

I also understand that a \$35.00 NSF fee will be charged for checks initially returned unpaid by my account. If the same check is returned a second time, I understand it may be referred to a collection service for recovery.

\_\_\_\_\_  
*Signature of Patient or Responsible Party*

\_\_\_\_\_  
*Date*



The Fertility Center  
of Las Vegas

The Fertility Center of Las Vegas

## Authorization for Release of Protected Health Information

I am scheduled at The Fertility Center of Las Vegas on \_\_\_\_\_,  
and the office has requested that medical records be forwarded to the office prior to my scheduled appointment.  
I hereby authorize:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To release a copy of the following information:

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> All Records | <input type="checkbox"/> History and Physical      |
| <input type="checkbox"/> Chart Notes | <input type="checkbox"/> X-rays/ultrasound reports |
| <input type="checkbox"/> Lab results | <input type="checkbox"/> Operative reports         |

To: The Fertility Center of Las Vegas  
8851 W. Sahara Ave., #100  
Las Vegas, NV 89117

Phone: 702.254.1777  
Fax: 702.254.1213

Medical records may include confidential information related to communicable disease, alcohol or drug abuse, genetic information, blood, breath, or urine screens, and mental health diagnosis and treatment.

I DO  DO NOT  Authorize the release this type of information.

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision to health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- I may have signed a copy of this authorization.

This authorization will expire on \_\_\_\_\_ (list date or event).

\_\_\_\_\_  
Patient or Personal Representative's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Description of Rep. Authority to Act for Patient

\_\_\_\_\_  
Date