

Infertility & IVF Medical Associates of W.N.Y.

4510 MAIN STREET · SNYDER, NEW YORK 14226

(716) 839-3057 FAX (716) 839-1477

PATIENT PERSONAL INFORMATION * ALL INFORMATION IS STRICTLY CONFIDENTIAL

Date _____

Referred by _____

Patient Name _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

Social Security No. _____

Home Phone _____ Marital Status _____

Employer _____

Address _____

City _____ State _____ Zip _____

Business Phone _____

Cell Phone _____

Husband's Name/Partner _____

D.O.B. _____

Social Security No. _____

Employer _____

Employers Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

In Case of Emergency notify:

Name _____

Phone # _____

Relation _____

Insurance Information - Primary (Self)

Plan Name _____

Policy Number _____

Group Number _____

Effective Date of Insurance _____

Secondary Insurance Additional Coverage (Spouse)

Does Patient Have Other Health Insurance? Yes No

If Yes, Name of Policy Holder _____

Plan Name _____

Policy Number _____

Group Number _____

Effective Date of Insurance _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Infertility & IVF Medical Associates of WNY all medical benefits. If any, otherwise payable to us for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance, including 33 1/3% collection costs and 50% attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of this signature on all submissions.

Signature of Insured: _____ Date _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made directly to Infertility & IVF Medical Associates of WNY for any services rendered to me. I authorize any medical information about me to be released to the Health Care Administration and its agents and to any other health insurance or on approved claim forms or electronically submitted claims. I understand my signature requests payment be made. In Medicare assigned cases, Infertility & IVF Medical Associates agrees to accept Medicare charge determination and I am responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary's Signature: _____ Date _____

Family History: Have your grandparents, parents, uncles, aunts, sisters or children ever been treated for:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Severe Deafness
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever or Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Disorders

Medical History: Have you had or do you presently have:

	Yes	No		Yes	No		Yes	No
Serious Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	German Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds or Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection or Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Veneral Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Allergy or Reaction to Medication	<input type="checkbox"/>	<input type="checkbox"/>
Rapid or Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>			
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization, Operations, Surgeries & reason	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>			
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

As of Now Do You Have Any of the Following Symptoms?

	Yes	No		Yes	No		Yes	No
Chills or Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Tarry Stool	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeding	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Night Urination	<input type="checkbox"/>	<input type="checkbox"/>
Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Sudden/Urgent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Sores in Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Painful Feet	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Sweating	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Feet	<input type="checkbox"/>	<input type="checkbox"/>
Unusual Hairgrowth	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hands/Face	<input type="checkbox"/>	<input type="checkbox"/>
Marked Tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin Sores	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation of Heart	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Worry	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in Breast	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Ringin in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in Neck	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	under arms or groin	<input type="checkbox"/>	<input type="checkbox"/>			
Disturbance of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or Vomiting	<input type="checkbox"/>	<input type="checkbox"/>			
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Change in Bowel Habit Pattern	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>			
Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Pus in Urine	<input type="checkbox"/>	<input type="checkbox"/>			

Do you smoke? Yes No If yes, how much? _____

Contraception Used? Yes No

Method Used: Diaphragm Rhythm Withdrawal Pills Name _____
 Rubber Condom Sponge/Foam Intrauterine Device Type _____
 Surgical Sterilization has been performed: Yes No Husband Self
 Type _____ Date _____

Menstrual History:

History of Herpes? _____
 Date Diagnosed _____ Date of last recurrence _____

Menstrual Cycle:

	YES	NO
Do you menstruate: Date of Last Pap Smear _____ Results of Pap: _____	<input type="checkbox"/>	<input type="checkbox"/>
Treatment required? _____		
Number of days between periods _____		
Average number of days of flow _____		
Up to this time periods have been:		
Regular <input type="checkbox"/> Somewhat irregular <input type="checkbox"/> Completely irregular <input type="checkbox"/>		
Menstrual flow now is Scant <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Excessive <input type="checkbox"/>		
Do you usually have clots with your periods?	<input type="checkbox"/>	<input type="checkbox"/>
Are your periods usually painful?	<input type="checkbox"/>	<input type="checkbox"/>
? Medication _____		
Do you ever have bleeding or spotting between periods?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have any bleeding or spotting following sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever have any pain with sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
Was your last menstrual period normal?	<input type="checkbox"/>	<input type="checkbox"/>
Date last menstrual period began _____		
Date the previous menstrual period began _____		
Menstruated first time at age of _____		
At first periods were Regular <input type="checkbox"/> Irregular <input type="checkbox"/>		
If not menstruating - stopped at age of _____		
Have you had any bleeding or spotting since menstruation stopped?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had Hot Flashes? Treatment _____	<input type="checkbox"/>	<input type="checkbox"/>

Obstetrical History:

SUMMARY OF PREVIOUS PREGNANCIES			Full Term		Premature		Abortions		Now Alive		Mult. Births
No.	Year	Place of Confinement	Sex	Dur. of Gestation	Dur. of Labor	Type of Delivery	Born A or D	Weight	Complications		Child
									Maternal		

Please state briefly present complaint, if any —

PHYSICAL EXAMINATION:

Date:

Name:

DOB:

Height:	Weight:	B.P.:	Normal	FINDINGS
Head				Pelvic BUS
Neck				Ext. Genit.
Chest				Introitus
Heart				Vagina
Breasts				Cervix
Scars				Uterus
Abdomen				Tubes
Liver				Ovaries
Spleen				Bladder
C.V.A.				Rectal
Spine				
Extremities				
Neurologic				

SUMMARY: _____

DIAGNOSIS: _____

PLAN: _____

MEDICATION/Prescription: _____
