Patient Information Form

(Must fill Out Completely)

Fertility Center of Dallas

J. Michael Putman, M.D., PA

Lily Zhang, Ph.D.

Patient

Last Name: _____First Name_____ Middle Initial

Preferred Name : _____ Email: _____

Social Security #: _____/_____/_____ D.O.B.: _____ /_____/_____

Home Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____

Employer Address: _____

Partner's Information

Last Name: _____First Name_____ Middle Initial

Preferred Name: _____ Email: _____

Social Security #: _____/_____/_____ D.O.B.: _____/_____/_____

Cell Phone: (_____) _____ Work Phone: (_____) _____

Name of Person(s) to whom we may release medical information to:

Name: _____ Phone: (_____) _____Relationship: _____

Name: _____ Phone: (_____) _____Relationship: _____

Emergency Contact: _____ Phone: (_____) _____Relationship: _____

Referred by: _____ Phone: (_____) _____

Address: _____

Preferred Pharmacy: _____ Phone: (_____) _____

Address: _____City_____State_____Zip_____

Signature: _____ **Date**: _____

FERTILITY CENTER OF DALLAS

Fertility Center of Dallas
J. Michael Putman, M.D., PA
Lily Zhang, Ph.D.

Reproductive Endocrinology and Infertility
Advanced Gynecologic Endoscopy

Baylor Medical Pavilion
3900 Junius St., Ste. 610
Dallas, TX, 75246
(214) 823-2692 (O)
(214) 887-8244 (F)

FERTILITY QUESTIONNAIRE - PATIENT

Name:_____ **Date:**_____ **Date of Birth:**_____ **Age:** _____

A. GENERAL INFORMATION

1) Height:_____ Weight: _____
2) How long have you been married? _____
3) How long have you been seeking a pregnancy? _____
4) Is this your first marriage? _____
5) Do you have children from this marriage? _____
   If yes, how many children? Adopted_____ Biological_____
6) Do you have children from a previous marriage(s) or relationship?
   If yes, how many children? Adopted_____ Biological_____

B. MENSTRUAL CYCLE

1) What age were you when menses started? _____
2) Are your menses regular?_____ Number of days in your cycle? _____
3) How many days of flow do you have in an average period? _____
4) What was the date of your last menstrual period? _____
5) How do you decide that ovulation is occurring? _____
6) Do you have pain when ovulating? _____
7) Do you have bleeding near ovulation? _____
8) What is your frequency of intercourse near ovulation? _____
9) Do you have mid-cycle bleeding? _____
10) Do you have pain with your menstrual flow? _____

11) Do you have spotting prior to the onset of a brisk menstrual flow? _____

12) Have you taken your basal body temperature during a menstrual cycle? _____

C. INTERCOURSE

1) How frequently do you have intercourse? _____
2) Do you use lubricants with intercourse? _____
3) Do you use douches near Intercourse? _____
4) Do you have pain with intercourse? _____

D. PREVIOUS PREGNANCIES

1) How many times have you been pregnant?_____Dates:
2) What was the outcome?

_____live birth	____therapeutic abortion
_____ectopic pregnancy	____spontaneous abortion
_____stillborn	____miscarriage

3) How long did it take to conceive in previous attempts at pregnancy?

E. CONTRACEPTION

1) Have you previously used contraception?
2) If yes, what form(s) of contraception?

_____contraceptive pill	_____intrauterine device
_____diaphragm	____other
_____condom	

F. MEDICAL/SURGICAL

1) Have you ever had surgery? If yes,

Procedure(s):	Date(s):	Place(s):

2) Have you recently lost or gained over 20 pounds? _____

3) Do you exercise regularly? If yes, how often and what type? _____

4) Do you follow any special dietary regimen? _____

5) Are you allergic to any medications? If yes, please list: _____

6) Do you take any herbal supplements or alternative medications?

If so, please list: _____

_____

_____

7) Do you use or have you used?

_____Prescription drugs or medications? If yes, please list:

_____

_____Non-prescription drugs or medications? If yes, please list:

_____

_____Marijuana or other drugs? What?_____ How much?_____

_____Tobacco products? What? _____ How much? _____

_____Alcoholic beverages? What? _____ How much? _____

8) Do you or have you ever:

_____Anemia
_____Appendicitis
_____Arthritis
_____Headache
_____Heart Disease
_____Hepatitis
_____Bronchitis
_____Excess Body/ Facial Hair
_____High Blood Pressure
_____Immunizations
_____Intolerance to Heat/Cold
_____Liver Problems
_____Visual Problems
_____Gall Bladder Problem
_____Gonorrhea
_____Ovarian Cysts
_____Pelvic Infection
_____Herpes
_____Hirsutism
_____Rheumatic Fever
_____Syphilis
_____Thyroid Problems
_____Ulcers
_____Urinary Tract Infection
_____Vaginitis
_____Measles-Regular or German
_____Blood Product Transfusions
_____Breast Discharge
_____Poor Sense of Smell
_____Cancer
_____Chlamydia
_____Colitis
_____Color Blindness
_____Diabetes
_____Dizziness
_____Endometriosis
_____Epilepsy Seizure

G. PREVIOUS FERTILITY EVALUATION AND TREATMENT

1) Have you had:

_____Hysterosalpingogram
_____Cervical Cauterization Laser Surgery
_____Fallopian Tube Surgery
_____Post Coital Examination
_____Urinary LH Testing
_____Medication for Fertility Treatment
_____Chromosome Studies
_____Hormonal Testing
_____Laparoscopy
_____Hysteroscopy
_____Dilatation and Curettage
_____Ultrasound Monitoring of Ovulation
_____Endometrial Biopsy
_____Insemination with Husband Semen
_____Insemination with Donor Semen

_____Previous Attempts with Assisted Reproductive Technology:

_____GIFT_____IVF_____TET_____ZIFT

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(214) 887-8244 (F)

FERTILITY QUESTIONNAIRE - PARTNER

Name:_____ Date of Birth:_____ Age: _____

A. GENERAL INFORMATION

1) How long have you been married? _____
2) How long have you been seeking a pregnancy? _____
3) Is this your first marriage? _____
4) Do you have children from this marriage? _____
   If yes, How Many Children? Adopted____Biological ____
5) Do you have children from a previous marriage(s) or relationships? If yes, how many children? Adopted___Biological ____

B. MEDICAL/SURGICAL

1) Have you ever had surgery?
   If Yes**,** Procedure_____ Place_____ Date_____

2) Have you recently lost or gained over 20 pounds? _____
3) Do you exercise regularly? _____
   If yes, how often and what type? _____
4) Do you have follow any special dietary regimen? _____
5) Do you use or have you used:
   _____Prescription drugs or medications? _____
   If yes, please list: _____
   _____Non- prescription drugs or medications? _____
   If yes, please list: _____

_____Herbal supplements or alternative medicine?
If yes, please list: _____
_____Marijuana or other drugs?

_____ Tobacco products?
What?_____How much? _____
_____Alcoholic beverages?
What? _____How much? _____

Do you have or have you ever had:

___Anemia	___Epilepsy Seizures	___Liver Problems
___Appendicitis	___Excessive Sweating	___Measles
___Arthritis	___Gall Bladder Problems	___Mumps
___Blood Product Transfer	___Gonorrhea	___Poor Sense of Smell
___Breast Discharge	___Headache	___Rheumatic Fever
___Bronchitis	___Heart Disease	___Cancer
___Hepatitis	___Thyroid Problems	___Chlamydia
___Herpes	___Ulcer(s)	___Colitis
___High Blood Pressure	___Problems w/Urination	___Color Blindness
___Impotency	___UTI	___Diabetes
___Immunizations	___Urethritis	___Dizziness

C. PREVIOUS FERTILITY EVALUATION AND TREATMENT

1) Have you had:
   ___Semen Analysis
   ___Sperm Antibody Assay
   ___Mucous Penetration Assay
   ___Hamster Egg Penetration Assay
   ___Testicular Biopsy
   ___Vasogram

2) Have you previously received fertility medication? If yes, please list _____

3) Have you had a hernia repair? If yes, where and when _____

4) Have you had a varicocele repair? If yes, where and when _____

5) Do you wear briefs or boxers? _____

6) Do you spend any amount of time in a sauna or hot tub more than 2 or 3 times a year?
   _____

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INSURANCE INFORMATION

Primary Insurance Company:

Insurance Address: Po Box

Member Services/Provider Phone Number:

Group #: Member or ID #:

Insured's Name: Insured's D.O.B

Insured's Employer: Phone#:

Patient's Name: Relationship to Insured:

Patient's Social Security #: Patient's Date of Birth:

I hereby assign, transfer, and set over to Fertility Center of Dallas, J. Michael Putman, M.D., P.A. all rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: Date:

FERTILITY CENTER
OF DALLAS

J. Michael Putman, M.D. & Associates
Advanced Gynecologic Endoscopy

3900 Junius Street, Ste 610
Dallas, Tx 75246
214-823-2696 Phone
214-887-8244 Fax

Insurance Policy

Our practice accepts insurance from most major insurance carriers. As a courtesy, our practice will review your insurance coverage, verify, coverage and obtain an authorization for treatment, if necessary, and file your claim with your insurance carrier. If a referral from your primary care physician is required it is your responsibility to provide the referral prior to treatment. (Please check your insurance card for the name of your PCP. While your OB/GYN might have recommended Dr. Putman, the physician designated on your card is the one who must send a written referral.)

Our practice will require you to assign all insurance company payments directly to our office to avoid any misunderstanding regarding payment for professional services. If you request your insurance company to pay you directly, we will require full payment when services are rendered. You will be responsible for any portion of your bill that is denied or not paid by your insurance carrier. Your insurance coverage is a contract between you and your insurance carrier; however, we will make every effort to maximize your insurance benefits.

If an insurance problem occurs please assist us in contacting your insurance carrier. We ask that you read and sign the Authorization for Claim Review, so that we may have it on file should it become necessary to ask for a review of claims submitted on your behalf. We feel it is necessary to work together to resolve any insurance problem.

All patients will be required to establish a written financial arrangement for payment when services are needed. All patients will be notified of any balance remaining after insurance payment has been received by our practice. Our staff will apply this payment to your account or refund any credit.

We firmly believe open communication is the basis for a good doctor/patient relationship. The business staff is committed to assisting you in any way possible to clarify any misunderstanding you have concerning you balance. If you have any questions concerning your insurance policy or need assistance, please contact our practice immediately.

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Financial Policy

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. All patients must have a signed Payment Agreement on file prior to treatment.

FULL PAYMENT IS DUE ATTIME OF SERVICE
WE ACCEPT CASH, CHECK, OR VISA/MASTERCARD/DISCOVER, AMERICAN EXPRESS

REGARDING INSURANCE

We may accept assignment of insurance benefits. However, we do require all co-pays and deductibles be paid at the time of service. The balance Is your responsibility whether your insurance company pays or not. We cannot bill your insurance carrier unless you. Give us complete insurance information your insurance company requires a referral for treatment. it is your responsibility to obtain the referral from your primary care physician prior to treatment. If your insurance company has not paid your account in full within 45 days, the balance will be due in full. Please be aware that some and perhaps all of the services provided may be non-covered service and not considered reasonable and necessary and are the patient's responsibility.

Regarding Insurance plans with which we are a participating provider must have insurance information prior to treatment in order to verify coverage. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating provider’s benefits are denied because they are not covered under your plan, refer to the above paragraph.

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 policy.

_____

Signature of Patient or Responsible Party Date:

_____

Signature of Co-Responsible Party Date:

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PATIENT NAME:_____APPT. DATE: _____ WITH DR. _____

Fertility Center of Dallas would appreciate your completing the following: Please include all information.

Referred by Dr: _____
Address:_____
Phone Number: Fax:

If you have the type of insurance that requires a primary care physician (the doctor's name on your **insurance card**), please complete the following

Name of **Primary Care Physician**: _____
Address:_____
Phone Number: Fax Number:

Number of visits authorized: (Please try to get this information)

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PAYMENT POLICY

The following information is provided to avoid any misunderstanding concerning payment for professional services.

- Prompt payment allows us to control cost. Therefore, all patient will be required to pay for services as rendered.
- It should be mentioned that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your claim and ensure your carrier remits payment. If a problem occurs with your claim, you will be required to establish written financial arrangement with our practice until your insurance problem is resolved.
- Each month you will receive a statement for services which will be due and payable within 30 days. If you need to discuss your account, please call the practice manager at: (214) 823-2692.
- All patients refusing to remit payment after 60 days of notice without pending insurance or financial arrangement will force us to limit their future credit until the previous balance is paid in full or written financial arrangement are accomplished. All patient will require to sign a written legal agreement with our practice to alleviate any current delinquency. Please notify us immediately if a mistake appears on your statement.
- Laboratory charges that are not part of the insurance plan.

  I am aware that the laboratory that contracts with my insurance company is unable to provide some services that are needed during my current treatment. I understand that I am personally responsible for these lab charges at the time of service. I will be informed of the cost and agree to pay for the test. I further understand that my insurance company will not refund these charges.

_____

Signature Date

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SPECIFIC PROCEDURE WAIVER

We make every effort to utilize the contracted laboratory of your insurance carrier. However, if your treatment requires the use of a specialized laboratory, you will be responsible for the cost of those tests. You will be informed of the cost of such test and are expected to pay for these tests on the day of service. We will not file your insurance for these specialized tests nor will we mediate on your behalf with your insurance company.

These procedures may include but are not limited to:

1. Comprehensive semen analysis with ultra-specific morphology. This is a comprehensive test performed by a high-complexity laboratory. Large contracted laboratories such as Lab Corp and Quest provide a standard semen analysis only; they do not offer studies which comprise a comprehensive semen analysis.
2. Sperm-washing
3. Intrauterine insemination
4. Reproductive Immunophenotype
5. Embryo Toxicity Assay (ETA)
6. Natural Killer Cell (NKA)
7. Holiday and Weekend fees
8. Education and Injection instruction classes
9. Hormone tests (i.e. Estradiol, Progesterone, Quantitative HCG) whose results must be done on the same day (STAT) during treatment. Large contact laboratories such as Lab Corp and Quest **cannot guarantee** same day results which will jeopardize the outcome of your treatment.

I have read and understand the above terms and conditions and accept financial responsibility.

_____

Patient Signature Date

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HIPAA Acknowledgement

I,_____have reviewed this office's policy on HIPAA, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

3900 Junius St., Ste., 610
Dallas, Texas 75246
Phone: 214.823.2692 Fax: 214.887.8244

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Gynecologic Endoscopy

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name	D.O.B.	Social Security#

I hereby request that my medical records be released:

To: J. Michael Putman, M.D.
Phone:214.823.2692 Fax:214.887.8244

From:_____
Physician/Facility

_____
Address

_____
City State Zip

_____
Phone Fax

_____
Signature of Patient Date