

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

DOB: \_\_\_/\_\_\_/\_\_\_



# Alabama Center for Reproductive Medicine

## Male New Patient Medical History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Initial Apt Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Height: \_\_\_\_\_

Occupation: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Contact #: \_\_\_\_\_ Secondary Contact #: \_\_\_\_\_

Email: \_\_\_\_\_ Race: \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_

Pharmacy City, State: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Partner name (if applicable): \_\_\_\_\_ Partner occupation: \_\_\_\_\_

Partner phone #: \_\_\_\_\_ Partner DOB: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

### History

Have you had a previous vasectomy? \_\_\_\_\_ Have you had it reversed? \_\_\_\_\_

History of infertility in a prior relationship? \_\_\_\_\_

Have you seen a urologist for infertility evaluation? \_\_\_\_\_ If yes, who? \_\_\_\_\_

When? \_\_\_\_\_

Have you had a semen analysis? \_\_\_\_\_ When? \_\_\_\_\_

Result: \_\_\_\_\_

Number of pregnancies with current partner: \_\_\_\_\_

Number of pregnancies with prior relationship(s): \_\_\_\_\_

List any sexually transmitted disease you have had (such as syphilis, gonorrhea, herpes, genital warts, ect): \_\_\_\_\_  
\_\_\_\_\_

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Alcohol consumption: Current \_\_\_\_\_ beverages/week Past \_\_\_\_\_ beverages/week

Have you ever smoked a cigarette? \_\_\_\_\_ If yes, when did you quit? \_\_\_\_\_

Cigarette use: Current \_\_\_\_\_ packs/day Past \_\_\_\_\_ packs/day

How many years have you smoked? \_\_\_\_\_

Do you dip or chew tobacco? \_\_\_\_\_ If you vape, how many times per day? \_\_\_\_\_

Recreational/illegal drug use (please specify): Current: \_\_\_\_\_

Past: \_\_\_\_\_

How many caffeinated beverages do you have per day? \_\_\_\_\_

Have you ever undergone chemotherapy or radiation? (If yes, please explain)

\_\_\_\_\_

Are you currently taking testosterone in any form? \_\_\_\_\_ Have you ever? \_\_\_\_\_

How long? \_\_\_\_\_

Do you have any medication allergies? \_\_\_\_\_

#### Current Medications

Medication	Frequency	Indication
_____	_____	_____
_____	_____	_____
_____	_____	_____

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### Review of Systems

#### General

- Weight loss or gain
- Fatigue
- Fever or chills
- Weakness
- Trouble Sleeping

#### Skin

- Rashes
- Lumps
- Itching
- Dryness
- Hair and nail changes

#### Ears

- Decreased Hearing
- Ringing in ears
- Earache
- Drainage

#### Eyes

- Glasses or contacts
- Pain
- Redness
- Blurry or double vision
- Flashing lights
- Specks
- Cataracts
- Glaucoma
- Last eye exam \_\_\_\_\_

#### Neck

- Lumps
- Swollen glands
- Stiffness
- Pain

#### Nose

- Stuffiness
- Discharge
- Itching
- Hay fever
- Nosebleeds
- Sinus pain

#### Throat

- Dry mouth
- Bleeding gums
- Dentures
- Sore throat
- Dry mouth
- Hoarseness
- Thrush
- Non-healing sores
- Last dental exam \_\_\_\_\_

#### Respiratory

- Sputum
- Wheezing
- Painful breathing
- Coughing up blood
- Shortness of breath
- Cough

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### Review of Systems Cont.

#### Urinary

- Increased frequency
- Urgency
- Burning or pain
- Blood in urine
- Incontinent
- Change in urinary strength

#### Vascular

- Calf pain with walking (claudication)
- Leg cramping

#### Neurological

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremors

#### Cardiovascular

- Difficulty breathing lying down
- Chest pain/discomfort
- Tightness
- Palpitations
- Swelling (adema)

#### Genital

- Pain with sex
- Hernia
- Sores
- Penile discharge
- Itching or rash
- STDs
- Erectile dysfunction
- Masses or pain

#### Hematologic

- Ease of bruising
- Ease of bleeding

#### Psychiatric

- Nervousness
- Depression
- Memory loss
- Stress

#### Musculoskeletal

- Muscle or joint pain
- Stiffness
- Back pain
- Redness of joints
- Swelling of joints
- Trauma

#### Endocrine

- Head or cold intolerance
- Sweating
- Excessive thirst (polydipsia)

#### Gastrointestinal

- Swallowing difficulties
- Change in appetite
- Nausea
- Constipation
- Rectal bleeding
- Change in bowel habits
- Heartburn
- Yellow eyes/skin
- Diarrhea

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Provider Notes:

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Plan:

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### Permission to Release Personal Health Information – Male Partner

Patient's name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Any physician, staff, employee or representative of Alabama Center for Reproductive Medicine has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following physicians and or other persons in order to facilitate and coordinate my care, treatment and payment:

Physician	Location	Phone Number	Fax Number

Name	Relationship	Phone number	Alternate phone number

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke this permission by writing to Alabama Center for Reproductive Medicine or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_/\_\_\_/\_\_\_

Patient's Signature

Guardian Signature (if minor)

Date

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

DOB: \_\_\_/\_\_\_/\_\_\_



# Alabama Center *for* Reproductive Medicine

## Authorization for Release of Information: Male Partner

Please send my complete medical records to:

**2006 Brookwood Medical Center Drive  
Suite 302  
Birmingham, AL 35209  
Phone: 205-307-0484  
Fax: 866-829-2082**

**7209 Copperfield Drive  
Montgomery, AL 36117  
Phone: 205-307-0484  
Fax: 866-829-2082**

Items Needed: Complete Medical Record

Purpose of Release: \_\_\_\_\_

I understand that:

- 1) This authorization is voluntary. I may refuse to sign this authorization, and my treatment and/or payment obligations will not be affected.
- 2) This authorization will remain in effect for one year, or until I revoke it in writing, which I may do at any time.
- 3) My records may contain hepatitis and HIV screening results that may be included in the record release.
- 4) The sender of this health information cannot guarantee that the recipient of the information will not re-disclose this information.
- 5) I have the right to receive a copy of this authorization form after I sign it.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Social Security #: \_\_\_\_\_ Telephone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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

DOB: \_\_\_/\_\_\_/\_\_\_



# Alabama Center *for* Reproductive Medicine

## Insurance Registration Form: Male Partner

Responsible Party:    Self    or    Other

Relationship to Patient: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Primary Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Secondary Phone #: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Please present your insurance cards and driver's license to the receptionist

Insurance Carrier	Policy #	Group #	Effective date	Policy holder

I authorize the release and disclosure of any or all of my medical and treatment records or reports to any other health care provider who may be of assistance, in the opinion of Alabama Center for Reproductive Medicine (ACRM), and/or for assisting in any reimbursement or medical benefits to which the patient may be entitled. I allow fax transmission of my medical records, if necessary. I further authorize and request that insurance payments be made directly to ACRM, should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of the assignment shall be considered as the effective and valid as the original.

I acknowledge full financial responsibility for services rendered by ACRM. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I authorize treatment by ACRM physicians and personnel. I have read and fully understand the above consent for release of medical information, insurance authorization, financial responsibility, and treatment.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's Signature

Guardian's Signature

Date



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

DOB: \_\_\_/\_\_\_/\_\_\_



# Alabama Center for Reproductive Medicine

## Notice of Privacy Practices – Male Partner

*This notice describes how medical information about you may be used and disclosed and about how you can get access to this information. Please review it carefully.*

*The policy of Alabama Center for Reproductive Medicine (ACRM) is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of ACRM.*

*Individually identifiable health and personal information are any information obtained by ACRM in connection with providing healthcare treatment, obtaining payment and related healthcare operations. This relates to past, present, or future information that ACRM receives from you as our patient.*

*ACRM collects personal information in order to learn about your medical history, medical conditions render treatment and collect payment for our services. We gather this information from your patient forms, health questionnaires and other forms you will be asked to complete from time to time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative and your family members. Your healthcare plan or insurance carrier may provide information to our office.*

*We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment and communications such as follow-up and appointment reminders, as well as treatment alternatives or other health-related benefits. We may leave a message on your answering machine or voicemail to contact you about appointments or to have you call our office. As a part of our standard treatment and healthcare operations, we may share our treatment plan with a facility such as a hospital, laboratory, diagnostic services or healthcare provider to efficiently coordinate your treatment plan. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. As required by your insurance contractor, we will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, pre-certification, utilization review and related activities for worker's compensation, information about a work-related condition can be exchanged with the employer.*

*Your information is maintained in our office in our practice management computer system. We also maintain information about you in our medical chart. ACRM limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy and receive an accounting disclosure of your medical & billing record. Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies.*

*We do not disclose personal information to third parties unless one of the following expectations applies:*



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

DOB: \_\_\_/\_\_\_/\_\_\_



# Alabama Center *for* Reproductive Medicine

## Authorization for Treatment:

I (we), \_\_\_\_\_ the undersigned patient(s) and responsible party(s), consent to necessary treatment by Alabama Center for Reproductive Medicine (ACRM), physicians; physicians taking call for ACRM, and/or any of the qualified employees of ACRM. Treatment to include venipuncture, medication, ultrasound, X-rays or other studies, and to perform any operations and/or procedures after discussion of the risks and benefits and consent to undergo other procedures deemed necessary or advisable in the judgment of the attending physician employee of ACRM, or his/her associates or assistants in the diagnosis and treatment of my condition(s). In the course of this treatment should it be necessary to consult with others, I hereby give my permission and consent for this organization to obtain and release medical records and other pertinent information on the undersigned patients, to/from other healthcare providers or agencies (including but not limited to Blue Cross/Blue Shield InfoSolutions).

\_\_\_\_\_  
Responsible Party

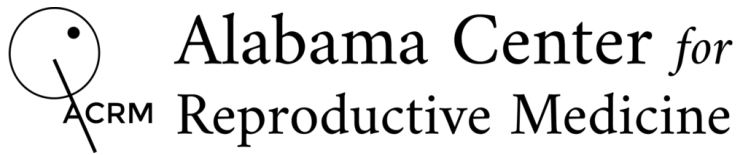
\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

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

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_



### Financial Responsibility Agreement

ACRM is committed to providing you with the best possible care and will help you receive the maximum allowable insurance benefits possible. We are here to assist you and are available to answer any questions you may have about your insurance coverage, but it is ultimately the patient's responsibility to inform themselves of their benefits and coverage. Please call our billing department at 205-307-0484 option 8 with your questions.

With your signature below, you hereby acknowledge and authorize the following:

1. Should my insurance carrier refuse payment (e.g., non-covered services, lapse in coverage, my failure to secure a referral from my primary care physician, provider is out of network, etc.) or if I am uninsured, I will pay for all services rendered upon receiving a written and/or verbal notice of the denial of my claim. I agree to pay all bills upon receipt of statement, unless other arrangements are made. I understand that payment is due and payable to The Alabama Center for Reproductive Medicine.
2. I understand that in order to be seen, any current balances must be paid down at 50% of the total at the time of check in with the remaining half being due prior to my next appointment.
3. I further agree and understand that this office can only code and file a claim for my visit(s) with the diagnosis that was encountered and documented in my medical record. Thus, to ask the office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.
4. In the event I do not pay for these or any other services provided to me when due, I agree to pay all costs associated with collection, including reasonable attorney fees (whether or not a law suit is commenced) as part of the collection process. I understand that any unpaid bills will be sent to collections at 120 days past due.

ACRM will submit your claim to your insurance plan. It is the responsibility of the patient to provide us with updated demographic and insurance information for accurate billing. All co-payments, deductibles, or non-covered services must be paid at the time of service, unless a payment agreement has been established. Fees for medical records include a \$5 search fee, \$1/page for 1-10 pages and \$25 for anything exceeding 10 pages. For patients who are uninsured, payment in full is required at the time of the visit for all services. A \$25 fee will be charged for all returned checks.

By my signature below, I certify to having read the above statements and fully understanding my financial responsibility for all care rendered to me so long as I am a patient of this practice regardless of any changes in my insurance coverage.

\_\_\_\_\_  
Signature of patient OR representative and relationship to patient

\_\_\_\_\_  
Date