

**PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)
FEMALE PATIENT HISTORY: INFERTILITY**

1. Identifying Information

Date: _____

Name: _____ Partner's Name _____

Address _____ City _____ State _____ Zip _____

Telephone No: Day () _____ Evening () _____

Cell Phone # _____ Referring Physician: Name _____

Practice Name _____ Address _____ Phone # _____

Age: _____ Date of Birth: _____ Partner's Age _____ Date of Birth _____

Race (check one) Caucasian African/American Asian Hispanic Jewish Mediterranean
 Other

II. Pregnancy History

How many pregnancies (including abortions) have you had? _____

*	When (year)	How long to conceive (months)	Fertility Therapy Used (Y/N)	Is Current Partner the Father (Y/N)	Duration of Pregnancy (months)	Outcome*	Complications
1st pregnancy							
2 nd pregnancy							
3 rd pregnancy							
4 th pregnancy							
5 th pregnancy							

*Outcomes: Vaginal delivery=VD; Cesarean Section=CS; Abortion=AB; Miscarriage=MS; Ectopic (tubal)= EP

III. Fertility History

How long have you and your present partner been trying to conceive: _____

How often do you have vaginal intercourse (sex) each week? _____

Have you ever been infertile with a past partner: yes no If so, how long: _____

Have you had any of the following tests performed: (Check all that apply and results)

	Date	Results
* Basal Body Temperature	_____	_____
* Urinary LH (Ovulation) Predictor Kits	_____	_____
* Post-coital Test	_____	_____
* Hormone Tests	_____	_____
* Endometrial Biopsy	_____	_____
* Hysterosalpingogram (HSG)	_____	_____
* Sonohysterogram	_____	_____
* Ultrasound	_____	_____
* Anti-sperm Antibodies	_____	_____
* Laparoscopy	_____	_____
* Hysteroscopy	_____	_____
*Gonorrhea/Chlamydia Cultures	_____	_____

- * Rubella (German measles) _____
- * Hepatitis B or C _____
- * HIV _____
- * RPR (Syphilis) _____
- * Blood type and Rh _____
- * Antibody Screen _____

What types of fertility therapy have you received in the past?

Drug / Treatment	Dosage	How Long or How Many Cycles	When
Clomiphene Citrate (Clomid Serophene)			
Gonadotropins (Pergonal, Repronex, Humegon, Metrodin, Fertinex, Gonal-F Follistim, Bravelle)			
HCG (Profasi, Pregnyl)			
Lupron, Zoladex, Synarel			
Progesterone			
Prednisone or Dexamethasone			
Bromocriptine (Parlodel) Dostinex			
Artificial Insemination			
Donor Insemination			
In Vitro Fertilization / ICSI			

IV. Gynecological History

How old were you when you started having periods: _____ Date your last period started: _____

Are your periods regular without medicines? ___ Yes ___ No

If yes, how many days between periods (start until start) _____

If no, how many periods per year do you have: _____

Do you require medicine (birth control pills or progesterone) to regulate your period? ___ Yes ___ No

How many days do your periods last: _____ Do you have cramps with your periods ___ Yes ___ No

If yes, are they ___ Mild ___ Moderate ___ Severe

Have you ever missed work of school due to menstrual pain: ___ Yes ___ No

Do you have pain with intercourse: ___ Yes ___ No

Were you ever diagnosed with endometriosis: ___ Yes ___ No

What type of contraceptive have you used in the past: (Check all that apply)

___ Birth Control ___ IUD ___ Depo Provera (birth control shots)

___ Condoms ___ Diaphragm ___ Foams/Jellies

___ Withdrawal ___ Rhythm ___ Tubal Ligation

Contraceptive Complications: _____

When did you last use contraception: _____

Have you ever had an abnormal Pap smear: ___ Yes ___ No If so, when: _____

What was done about it: _____

When was your last Pap smear: _____ Doctor/Practice: _____

Have you ever had any of the following: (Check all that apply)

___ Gonorrhea	___ Venereal Warts	___ Syphilis
___ Chlamydia	___ Genital Herpes	___ Pelvic Inflammatory Disease PID

How many sexual partners have you had in the past? _____

V. Medical History

Do you or have you ever had: (Check all that apply)

<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression / Anxiety	<input type="checkbox"/> Polycystic Ovarian Syndrome
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Gallbladder Problems	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rubella (German Measles)
<input type="checkbox"/> Breast Discharge	<input type="checkbox"/> Hirsutism (excess facial hair)	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Breast Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Colitis	<input type="checkbox"/> Neurological Problems	<input type="checkbox"/> Vision Problems

List any other medical conditions or problems (current or past): _____

Current Medications: (prescribed or over the counter) _____

Natural, herbal or alternative medicines _____

Are you allergic to any medications: Yes No What: _____

Are you allergic to latex Yes No; Iodine/Shrimp/Shellfish Yes No; Peanuts Yes No

Have you ever had surgery before: Yes No Date and type _____

VI. Social History

Current or Recent Employer/Position _____

Do you drink alcohol: Yes No Number of drinks per week: _____

Do you smoke: Yes No Number of cigarettes per day: _____ Number of years smoking: _____

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc): Yes No
If yes, please specify: _____

Do you have a special exercise program: Yes No
If yes, type: _____ Number of hours per week: _____

Are you on a special diet: Yes No

VII. Review of Systems:

What is your height: _____ Current weight: _____ Ideal Weight: _____

Have you had more than a 10 pound weight gain/loss this past year: Yes No
If so how much: _____ Was this intentional: Yes No

What is your blood type: (if known) A B AB O Rh (Positive, Negative) _____
Do you have problems with your eyes, ears, nose or throat: Yes No

If yes, please specify: _____
Do you have heart problems, chest pain or irregular heart beat: Yes No

If yes, please specify: _____
Do you have asthma, wheezing, shortness of breath or trouble breathing: Yes No

If yes, please specify: _____

Do you have breast pain, breast discharge or a lump in your breast: Yes No
 If yes, please specify: _____

Do you have chronic nauseas, twitching, stomach pain, blood in your stool or a history of ulcers: Yes No
 If yes, please specify: _____

Do you have urinary burning, incontinence or blood in your urine: Yes No
 If yes, please specify: _____

Do you have chronic joint or muscle pain or swelling? Yes No
 If yes, please specify: _____

Do you have any chronic skin rashes or moles: Yes No
 If yes, please specify: _____

Do you have changes in cold or hot tolerance, changes in skin tone or body hair growth: Yes No
 If yes, please specify: _____

Any history of (or family members with) blood clot problems or bleeding disorder: _____

VIII. Family History

Any history of breast cancer, ovarian or colon cancer: Yes No

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you: Yes No

Do any family members have significant health problems or inherited diseases: Yes No

Check all that apply:

<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Brain/Spinal Defects	<input type="checkbox"/> Fragile X Syndrome	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tay-Sachs Disease
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Thalassemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease

Who: _____

I confirm that all the above information is true and valid to the best of my knowledge. I also agree that this information or my medical records from this office may be subject to peer review by an outside agency if needed for any credentialing organization.

Signed: _____ Date: _____

PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)

New Patient Information (FEMALE)

Patient Registration Date _____

Contact Preference (please circle one): Home Cell Email

Patient's Full Name _____ Patient's Nickname/AKA _____
(Last Name) (First Name) (Middle Initial)

Maiden Name _____

Email address _____ Permission to email: Yes ___ No ___

Patient's Social Security No. (**required field**) _____ Cell Phone# () _____

Address 1:(Street Address) _____ Address 2: (PO Box, Apt, Ste #) _____

City _____ County _____ State _____ Zip _____ Home Ph # () _____

Birthdate _____ Sex M or F _____ Race _____ Marital Status _____

Patient's Employer _____ Address _____

City _____ State _____ Zip _____ Patient's Employer Phone No () _____

Partner/Spouse: Name _____ Birthday _____

Emergency Contact _____ Relationship to Patient _____

Emergency Contact Address _____ City _____ State _____ Zip _____

Emergency Contact Phone No (864) _____ Emergency Contact Employer _____

Employer Phone No. (864) _____

This is the person responsible for the balance after insurance pays on the account.

"If 18 or older, you are your own guarantor and do not have to fill out this section."

Guarantor Name _____ Guarantor Phone No. _____ Relationship to Patient _____

Guarantor Social Sec No. _____ Guarantor Address _____

City _____ State _____ Zip _____ Guarantor Employer _____

Address _____ City _____ State _____ Zip _____

Guarantor Employer Phone No. _____

Is visit result of liability accident? () Yes () No (Examples: auto accident, workers compensation, etc.)

If you checked "Yes" to this question, return to the receptionist for additional form

AUTHORIZATION: I will be responsible for any amount not covered by insurance. I authorize _____ to provide medical evaluation and treatment, and release information for Insurance/medical purposes concerning my illness and treatment.

Signature of Authorized Person: _____ Date: _____

METHOD OF PAYMENT FOR VISIT TODAY, PLEASE CHECK ONE:

CASH _____ CHECK _____ CREDIT CARD _____ DEBIT CARD _____

PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)

Patient MRN/Chart # _____

Patient D.O.B. _____

PRIMARY INSURANCE INFORMATION

Referred to Our Office By (Physician) _____ Phone No. () _____
(required field)

Insurance Company Name _____ Effective Date: _____
(Must be complete)

Ins Company Claim Mail Address _____ City _____ State _____ Zip _____

Phone No () _____ Policy Type _____ Certificate No. _____ Group No. _____
(Example: Group, Individual, Medicare, Medicaid, etc)

Primary Co-Pay \$ _____ Specialty Co-Pay \$ _____ Patient Employment Status _____
Example: employed full-time, part-time, retired,
Military, unemployed, full or p/time student

Insured/s/Subscriber's Full Name _____ (enter name exactly as it appears on INS card)
(If insured or subscriber is same as the patient DO NOT COMPLETE THIS NEXT SECTION)

Relationship to patient _____ Subscriber's Address _____

City _____ State _____ Zip _____ Subscriber's Phone No. _____ Subscriber's DOB _____

Subscriber's Sex _____ Subscriber's Social Security No. _____ Subscriber's Employer _____

Address _____ City _____ State _____ Zip _____

Employer Phone No. () _____ Certificate No. or Soc Sec No. _____ Group No. _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name _____ Effective Date _____
(Must be complete)

Ins. Co Claim Mail Address _____ City _____ State _____ Zip _____

Phone No. () _____ Policy Type _____ Certificate No. _____ Group No. _____
(Example: Group, Individual, Medicare, Medicaid, etc)

Primary Co-Pay \$ _____ Specialty Co-Pay \$ _____ Patient Employment Status _____
Example: employed full-time, part-time, retired,
Military, unemployed, full or p/time student

Insured's/Subscriber's Full Name _____ (Enter name exactly as it appears on Ins Card)

(If insured or subscriber is same as the patient, DO NOT COMLETE THIS NEXT SECTION)

Relationship to Patient _____ Subscriber's Address _____

City _____ State _____ Zip _____ Subscriber's Phone No () _____ Subscriber's DOB _____

Subscriber's Sex _____ Subscriber's Soc Sec No. _____ Subscriber's Employer _____

Address _____ City _____ State _____ Zip _____

Employer Phone No. () _____

BRING ALL INSURANCE CARDS AND DRIVER'S LICENSE WITH YOU FOR US TO MAKE COPIES. THANK YOU!

Piedmont Reproductive Endocrinology Group
117 Caledon Ct, Ste C, Greenville SC 29615
1330 Boiling Springs Road, Spartanburg SC 29303
675 Biltmore Avenue, Ste H, Asheville NC 28803

HIPAA NOTICE OF PRIVACY PRACTICES

Name _____

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

This notice of Private Practices describes how we may use and disclose your protected health information (PHI). To carry out treatment, payment or health care operations (TPO) and for other purposes That are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you including demographic Information, that may identify you and that relates to your past, present and future physical or mental Health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physician's practice and other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination and management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require protected information to be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate a physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect, Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donations: Research: Criminal Activity: Military Activity: National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law we must make disclosures to you when required by the

Page 2 HIPAA Notice of Private Practices continued

Secretary of the Department of Human Services to investigate or determine our compliance with requirements of the Section 164.500,

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indication in this authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information: **You have a right** to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records:

Psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, Criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have a right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that part of your protected healthcare information not need be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to the restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, then your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us even if you have agreed to accept this notice electronically.

You may have the right to have your physician amend your protected health information. If we deny the request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a cop of the rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you filing a complaint.** This notice was published and becomes effective on-or before April 14, 2003.

We are required by law to maintain the privacy of, and provide for individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak to **Faith Westbrook, our Practice Manager in person or at 864-232-7734.** By signing this form you are also agreeing to peer review of your medical records if needed. Signature below is only acknowledgment that you have received this Notice of Privacy Practices.

Print Name _____ Signature _____

Date _____

Piedmont Reproductive Endocrinology Group, P.A.
PAYMENT POLICY

Patient's Name _____ **Account No.** _____

Our mission at Piedmont Reproductive Endocrinology Group is to provide quality and cost-effective healthcare to our patients. As a courtesy, we participate in most major health care plans to make that care more accessible. Please take a moment to review the following information in order to better understand our policies regarding payment for services, tests and procedures.

PREG REPSONSIBILITES:

- * Provide you with cost-effective quality healthcare services.
- * Verify insurance benefits and eligibility of coverage for our services.
- * Provide you and/or your insurance company with a timely and accurate statement of all charges for services rendered.
- * Secure all pre-authorizations and/or referrals that your health insurance plan requires a physician's office to obtain for your ongoing care or treatment.

PATIENT RESPONSIBILITIES:

- * Provide PREG with proof of your current insurance information, employment, and demographic information at the time of each visit. Notify us within ten (10) days if you have a change in insurance status.
- * Understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us.
- * Pay in full your expected portion for the balance of your account at the time of service. This includes co-pays deductibles and payment for non-covered services.
- * Pay in full within ten (10) days of receiving a billing statement from our office for any remaining balance on your account. Any balances older than 30 days, which have not been paid by your insurance company, will be billed to you.

BILLING:

Insurance reimbursement is a contract between you and your insurance company. We file all insurance claims (only if you have coverage for the specific procedure) for plans with which we have a contractual relationship. All other claims are filed as a courtesy only. If your insurance claim has not been paid or settled within 30 days from the date of service, then you will be billed for the balance. Current laws regarding fraud and abuse with billing procedures prohibit us from changing your procedure codes and/or diagnosis codes "just to get your claim paid". We make every attempt to code and file claims accurately according to the services rendered and your healthcare provider's documentation on your medical record. Please call our office at 864-232-7734 should you have any questions or need to discuss your account.

INSURANCE:

YOUR INITIALS _____

PREG participates in several different health insurance plans. Our staff works diligently to assist you in using your insurance coverage wisely; however, it is your responsibility to understand the limits and restrictions affecting coverage for services provided by our specialty. Insurance plans rarely cover all services and procedures or pay for the entire amount of covered services. You will be expected to pay for the following at the time of service:

Patient's Name _____ **Account No.** _____

- *All co-pays, deductibles, and co-insurance amounts not covered by a secondary insurance policy.
- *The entire amount of any non-covered services.
- *The entire amount for service or procedures if we have not yet received a required authorization or referral from your primary care physician, insurance company or employer.
- *The entire amount of any services rendered if we are unable to verify your insurance coverage at the time of service.

SELF PAY:

YOUR INITIALS: _____

Patients who do not have insurance coverage (or proof of coverage) or who choose to pay for services not covered at PREG are expected to pay in full at the time of service. If you cannot pay the full amount of your bill, then you must make satisfactory payment arrangements with your financial counselor prior to receiving services.

Please be aware that PREG will not file any charges to your insurance company for any service or procedure if you do not have coverage for infertility testing or treatment.

ACCEPTANCE: Signature below indicates understanding of this policy and agreement to pay any portion of services not covered by insurance and/or any outstanding account balance at the time of service.

Party responsible for Account

Date

Witness

Date

PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)
17 Caledon Court Suite C, Greenville SC 29615
864-232-PREG (7734)

NEW PATIENT INFORMATION FACT SHEET

To all women attempting to conceive, it is recommend by our office and by the American College of Obstetricians and Gynecologists (ACOG):

- To be on a prenatal vitamin or a multivitamin with at least 400 micrograms of Folic Acid daily.
- Discontinue any tobacco products (both partners) before attempting pregnancy for at least 1- 2 months prior if possible. Cigarette smokers and patients expose to second-hand smoke have as much as a **50% reduction in fertility success rates** as compared to non-smokers. Cigarette smoke has significant adverse effects on the ovaries and egg quality. In addition, smoking while pregnant can have damaging effects on your developing baby.
- Nicotine products (gum, patches, etc.) can be used to help with smoking cessation but hopefully discontinued as soon as possible. In general, Nicotine products are much less harmful than cigarette smoke or other tobacco products for pregnancy and success for pregnancy.
- Discontinue any illegal drug use or heavy alcohol use (consumption of more than 2 drinks/day) while attempting pregnancy for both partners.
- Try to limit caffeine consumption to no more than two caffeinated drinks per day.
- Have a prenatal profile blood sample performed which test for: Blood type, antibody screen and Rh factor; Complete blood count (CBC), which test for anemia; blood tests for HIV, Hepatitis B and C, syphilis; and testing for immunity to Rubella (German Measles).
 - **Please initial if you desire to be tested: Yes_____ No _____**
- If you are not immune to Rubella, a vaccine can be obtained at the Health Department that can be given prior to attempting pregnancy.
- Additional testing for Cystic Fibrosis (CF) is also recommended for those of Jewish, European or Caucasian descent.
 - **Please initial if you desire to be tested: Yes_____ No _____**
- Testing for immunity to Varicella (Chicken Pox) can also be performed if requested if you have no history of having Chicken Pox or the have not been vaccinated as a child.
 - **Please initial if you desire to be tested: Yes_____ No _____**

Please inform your physician or the office staff if you desire to have any of the above testing performed to ensure that it is done!!!

- If you are on any prescription medications for any health conditions, please inform your physician.
 - Specific medications such as **ACE inhibitors** (for high blood pressure, **Accupril, Captopril, Monpril, Prinivil**), seizure disorder medications such as **Depakot, Depakene, and Valproic Acid** should be changed to other types of medications as they should not be used in pregnancy. Please consult your family physician concerning these medications.
 - Anti-depressant medications such as **Prozac, Paxil, Zoloft, Effexor, Celexa, Lexapro, Wellbutrin, and Sarafem** are fine to continue while attempting pregnancy but should be used at the lowest dose possible and consider stopping them once you are pregnant if possible.

- If you are on any over-the-counter hormonal or herbal supplements, please inform your physician.
- May continue with diet and exercise program to keep appropriate body weight if overweight. If underweight, we recommend decreasing any exercise program and increasing caloric intake. If you are on a weight loss medication (prescription, over the counter or herbal supplement) please inform your physician.
- It is recommended to be at an appropriate Body Mass Index (BMI) to improve your chances for pregnancy success and reduce complication of weight problems with pregnancy. In general, a BMI between 19 and 28 is within reasonable guidelines.
- To determine your BMI: divide your weight in kilograms by your height, in meters squared (kilograms/meters²). A simpler calculation can be done by multiplying your weight in pounds by 703 and then dividing that figure by your height, in inches squared, and this will give you your BMI. You might need a calculator to figure this one out!!
 - For example: A 5 foot 4 inch (64 inches) person weighing 135 pounds would have a BMI of 23.2 (rounded off).

$$\frac{135 \text{ (lbs.)} \times 703}{64 \text{ (in)} \times 64} = \frac{94905}{4096} = 23.17 \text{ BMI}$$

- Good diet programs are Weight Watchers and meal replacement programs (Slim-Fast). Low carbohydrate diets work best with usually <1800 calories intake per day
- Regular exercise program in combination with diet plan works well for weight loss. Use of a pedometer (measures amount of steps taken per day) can be very helpful with goal of 10,000 steps or greater per day.

Please inform your physician or the office staff if you desire to have any of the above testing performed to ensure that it is done!!!

Patient Signature: _____ **Date:** _____

Piedmont Reproductive Endocrinology Group, P.A.

John E. Nichols, M.D.

John F. Payne, M.D.

17 Caledon Court Suite C
Greenville, S.C. 29615
Office (864) 232-7734
Fax (864) 232-7099

1330 Boiling Springs Rd.
Suite 2200
Spartanburg, S.C. 29303
Office (864) 583-2669
Fax- (864) 583-2459

675 Biltmore Ave, Suite H
Asheville, NC 28803
Office (828) 210-8284
Fax (828) 350-7516

Authorization for Release of Medical Records

Today's Date: ___/___/___

Patient's Name: _____

SSN: ___/___/___

Patient's Date of Birth: ___/___/___

Daytime Phone: (___) ___-___

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

I authorize that my medical records be sent _____ TO _____ FROM _____ TO _____ FROM _____
PREG office (circle one) Greenville Spartanburg Asheville
(see addresses above)
(Practice, Individual, Organization)
(Mailing Address)
(City) (State) (Zip)

Records requested include: ___ office notes ___ labs ___ ultrasounds ___ HSG ___ paps ___ MMG
___ operative/surgery report: type of surgery _____ date _____ Doctor _____
___ operative/surgery report: type of surgery _____ date _____ Doctor _____
___ operative/surgery report: type of surgery _____ date _____ Doctor _____
___ pathology report(s) for above surgery (ies)
___ other _____

This authorization places no restrictions on any information to be released. If any restrictions are to be placed on information being released, please state: _____.

PREG can only release medical records generated by this practice.

Signature of Patient _____ Date _____

Witness _____ Date _____

Date records released or faxed: _____

**PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)
MALE PATIENT HISTORY: INFERTILITY**

I. Identifying Information

Date: _____

Name: _____ Partner's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. Day () _____ Evening/Cell () _____

Referring Physician: Name _____

Address _____

Age: _____ Date of Birth: _____ Partner's Age _____ Date of Birth: _____

Race: (check one) Caucasian African/American Asian Hispanic
 Jewish Mediterranean Other

II. Fertility History

How long have you and your present partner been trying to conceive: _____

Have you ever been infertile with a past partner: Yes No If so, how long: _____

Have you ever fathered a pregnancy before (including miscarriages/abortions/other partners): Yes No

If yes, explain: _____

Have you had any of the following tests performed: (Check all that apply and results)

	Date	Results
<input type="checkbox"/> Semen Analysis	_____	_____
<input type="checkbox"/> Anti sperm Antibodies	_____	_____
<input type="checkbox"/> Gonorrhea/Chlamydia Cultures	_____	_____
<input type="checkbox"/> Hormone Tests	_____	_____
<input type="checkbox"/> Urological Exam	_____	_____

III. Medical History

Do you have or have you ever had: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Abnormal Puberty | <input type="checkbox"/> Diabetes <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallbladder Problems <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Heart Disease <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis <input type="checkbox"/> Rubella (German measles) |

- | | | |
|---|---|---|
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> HIV | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Undescended testicle (s) | |

Current Medications: _____

Are you allergic to any medications: Yes No What: _____

Have you ever had surgery before: Yes No Date & type _____

Have you ever had injury to your genitals? Yes No Specify: _____

Do you have difficulty with erection ejaculation or decreased libido (sexual desire) ?

How often do you have vaginal intercourse (sex) with your partner each week? _____

Have you ever had any of the following: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Exposure to Radiation |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Prolonged Exposure to Chemicals |
| <input type="checkbox"/> Venereal Warts | <input type="checkbox"/> Prostatitis | |

IV. Social History

Current or Recent Employer / Position _____

Do you drink alcohol: Yes No Number of drinks per week: _____

Do you smoke: Yes No Number of cigarettes per day _____ Number of years smoking: _____

Do you now, or have you ever, used illicit drugs (marijuana, cocaine, etc) Yes No
If yes, please specify: _____

Do you have a special exercise program: Yes No
If yes, type: _____

Are you on a special diet: Yes No

V. Review of Systems

What is your height? _____ Current weight: _____ Ideal weight: _____

Have you had more than a 10 pound weight gain / loss this past year: ___ Yes ___ No

If so how much: _____ Was this intentional: ___ Yes ___ No

What is your blood type (if known) _____

VI. Family History

Any history of breast cancer, ovarian or colon cancer: ___ Yes ___ No

Did your mother take diethylstilbestrol (DES; a tablet given to women with a history of miscarriage or bleeding during pregnancy) when she was pregnant with you: ___ Yes ___ No

Do any family members have significant health problems or inherited diseases: ___ Yes ___ No

Check all that apply and state relationship to you:

<input type="checkbox"/> Birth defects	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Brain / Spinal defects	<input type="checkbox"/> Fragile X Syndrome	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Cancer (what type)	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tay-Sachs Disease
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Thalassemia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease

Who: _____

VII. Additional Health Information

Please bring this form with you to your first appointment. Ensure that records from your current of past physician have been sent or faxed to the address below at least one week in advance of your visit. We look forward to meeting you.

I confirm that all of the above information is true and valid to the best of my knowledge. I also agree that this information or my medical records from this office may be subject to peer review by an outside agency if needed for any credentialing organization.

Signed: _____ Date: _____

PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)

New Patient Information (MALE)
Patient Registration Date _____

Patient's Full Name _____ Patient's Nickname/AKA _____
(Last Name) (First Name) (Middle Initial)

Patient's Social Security No. (required field) _____ Cell Phone# () _____

Email address _____ Permission to email Yes ___ No ___

Address I:(Street Address) _____ : (PO Box, Apt, Ste #) _____

City _____ County _____ State _____ Zip _____ Home Ph # () _____

Birthdate _____ Sex M or F _____ Race _____ Marital Status _____

Patient's Employer _____ Address _____

City _____ State _____ Zip _____ Patient's Employer Phone No () _____

Partner/Spouse: Name _____ Birthday _____

Emergency Contact _____ Relationship to Patient _____

Emergency Contact Address _____ City _____ State _____ Zip _____

Emergency Contact Phone No (864) _____ Emergency Contact Employer _____

Employer Phone No. (864) _____

This is the person responsible for the balance after insurance pays on the account.
"If 18 or older, you are your own guarantor and do not have to fill out this section."

Guarantor Name _____ Guarantor Phone No. _____ Relationship to Patient _____

Guarantor Social Sec No. _____ Guarantor Address _____

City _____ State _____ Zip _____ Guarantor Employer _____

Address _____ City _____ State _____ Zip _____

Guarantor Employer Phone No. _____

Is visit result of liability accident? () Yes () No (Examples: auto accident, workers compensation, etc.)

If you checked "Yes" to this question, return to the receptionist for additional form

AUTHORIZATION: I will be responsible for any amount not covered by insurance. I authorize _____ to provide medical evaluation and treatment, and release information for Insurance/medical purposes concerning my illness and treatment.

Signature of Authorized Person: _____ Date: _____

METHOD OF PAYMENT FOR VISIT TODAY, PLEASE CHECK ONE:

CASH _____ CHECK _____ CREDIT CARD _____ DEBIT CARD _____

PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP (PREG)

Patient MRN/Chart # _____

Patient D.O.B. _____

PRIMARY INSURANCE INFORMATION

Referred to Our Office By (Physician) _____ Phone No. () _____
(required field)

Insurance Company Name _____ Effective Date: _____
(Must be complete)

Ins Company Claim Mail Address _____ City _____ State _____ Zip _____

Phone No () _____ Policy Type _____ Certificate No. _____ Group No. _____
(Example: Group, Individual, Medicare, Medicaid, etc)

Primary Co-Pay \$ _____ Specialty Co-Pay \$ _____ Patient Employment Status _____
Example: employed full-time, part-time, retired,
Military, unemployed, full or p/time student

Insured/s/Subscriber's Full Name _____ (enter name exactly as it appears on INS card)
(If insured or subscriber is same as the patient DO NOT COMPLETE THIS NEXT SECTION)

Relationship to patient _____ Subscriber's Address _____

City _____ State _____ Zip _____ Subscriber's Phone No. _____ Subscriber's DOB _____

Subscriber's Sex _____ Subscriber's Social Security No. _____ Subscriber's Employer _____

Address _____ City _____ State _____ Zip _____

Employer Phone No. () _____ Certificate No. or Soc Sec No. _____ Group No. _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name _____ Effective Date _____
(Must be complete)

Ins. Co Claim Mail Address _____ City _____ State _____ Zip _____

Phone No. () _____ Policy Type _____ Certificate No. _____ Group No. _____
(Example: Group, Individual, Medicare, Medicaid, etc)

Primary Co-Pay \$ _____ Specialty Co-Pay \$ _____ Patient Employment Status _____
Example: employed full-time, part-time, retired,
Military, unemployed, full or p/time student

Insured's/Subscriber's Full Name _____ (Enter name exactly as it appears on Ins Card)

(If insured or subscriber is same as the patient, DO NOT COMLETE THIS NEXT SECTION)

Relationship to Patient _____ Subscriber's Address _____

City _____ State _____ Zip _____ Subscriber's Phone No () _____ Subscriber's DOB _____

Subscriber's Sex _____ Subscriber's Soc Sec No. _____ Subscriber's Employer _____

Address _____ City _____ State _____ Zip _____

Employer Phone No. () _____

BRING ALL INSURANCE CARDS AND DRIVER'S LICENSE WITH YOU FOR US TO MAKE COPIES. THANK YOU!

Piedmont Reproductive Endocrinology Group
117 Caledon Ct, Ste C, Greenville SC 29615
1330 Boiling Springs Road, Spartanburg SC 29303
675 Biltmore Avenue, Ste H, Asheville NC 28803

HIPAA NOTICE OF PRIVACY PRACTICES

Name _____

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

This notice of Private Practices describes how we may use and disclose your protected health information (PHI). To carry out treatment, payment or health care operations (TPO) and for other purposes That are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you including demographic Information, that may identify you and that relates to your past, present and future physical or mental Health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physician's practice and other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination and management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require protected information to be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate a physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect, Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donations: Research: Criminal Activity: Military Activity: National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law we must make disclosures to you when required by the

Page 2 HIPAA Notice of Private Practices continued

Secretary of the Department of Human Services to investigate or determine our compliance with requirements of the Section 164.500,

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indication in this authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information: **You have a right** to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records:

Psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, Criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have a right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that part of your protected healthcare information not need be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to the restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, then your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us even if you have agreed to accept this notice electronically.

You may have the right to have your physician amend your protected health information. If we deny the request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a cop of the rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you filing a complaint.** This notice was published and becomes effective on-or before April 14, 2003.

We are required by law to maintain the privacy of, and provide for individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form please ask to speak to **Faith Westbrook, our Practice Manager in person or at 864-232-7734.** By signing this form you are also agreeing to peer review of your medical records if needed. Signature below is only acknowledgment that you have received this Notice of Privacy Practices.

Print Name _____ Signature _____

Date _____

LIST OF POSSIBLE REPRODUCTIVE TOXINS

Any history or use of the below in the past 3-6 months can affect sperm functions:

- Recent inflammation or infection of any type
- High fever associated with sickness or inflammation
- Extensive use of hot baths, hot tubs or saunas (more than 2-3 times per week)
- Cigarette smoking or use of any tobacco products, especially heavy smoking (more than a 1 pack per day)
- Heavy alcohol use (more than 2- 3 drinks/beers per day)
- Use of any recreational drugs (marijuana, cocaine, speed, crack, etc.)
- Frequent exposures to pesticides
- Heavy metal exposure (Mercury, Lead, Cadmium)
- Chronic exposure to heavy traffic/industry related air pollution
- Frequent exposure to solvents such as gasoline, kerosene, and crude oil products
- Chronic exposure to fumes of chemicals employed in stained glass soldering
- Chronic inhalation of vapors of non-water based paints and thinners/removers
- Chronic exposure to low doses of gamma irradiation
- Sulfa-based drugs
- Lithium
- Tetracyclines and particularly Doxycycline
- Strong pain killing drugs (Demerol, Morphine, Vicodin, Lortab, Tylox, Oxycotin, etc.)

Professions that can increase exposures to reproductive toxins:

- Artist (stained glass/photography/painting/soldering)
- Mechanics (car, motors, aviation, machines etc.)
- Metal workers doing extensive soldering
- Paint shops
- Solvent shops (including gas station)
- Painters (art/furniture/cars/industrial)
- Pesticide industry (manufacturer, distributor, extermination service etc.)
- Nuclear Engineers

Recommend that all males be on a multivitamin daily that includes at least:

400 units of Vitamin E
1000 mgs of Vitamin C
70 micrograms (mcg) of selenium
50 micrograms of zinc
400 micrograms of folic acid
6 micrograms of Vitamin B12

Fertility Blend (www.fertilityblend.com) and Fertile One (www.fertileone.com) are supplements that have all of the above ingredients and can be purchased on-line without a prescription