FAX BACK TO: 404-256-9497

OR EMAIL TO: mary.viskup@rba-online.com

PATIENT REGISTRATION FORM 1 of 8

Hello! Welcome to our office. We are anxious to make your appointment as convenient as possible. Would you please help us by furnishing the information requested below. This will be used to complete your record and will be kept strictly confidential. Carlene W. Elsner, M.D., F.A.C.O.G., Dorothy Mitchell-Leef, M.D., F.A.C.O.G., Michael A. Witt, M.D., F.A.C.S., Daniel B. Shapiro, M.D., F.A.C.O.G., Andrew A. Toledo, M.D., F.A.C.O.G., Scott M. Slayden, M.D., Robert J. Straub, M.D., and Pavna K. Brahma, M.D., reserve the right to assign any physician in their employ to participate in your medical care and that such assignment may be changed at their discretion. Should your address change at any time, please fill out another one of our information sheets. Should you ever need to cancel an appointment, please call and let the office know as soon as possible. If you have any questions about your care, your appointment or our fees, please feel free to discuss them with us. THANK YOU!!

First Name:	Home Phone:
Middle Name:	E-mail Address:
Last Name:	Social Security #:
Address 1:	Race:
Address 2:	Marital Status:
City:	Date of Birth:
State:	Country:
Zip:	Age:
Employer:	Work Phone:
City:	Occupation:
State:	Zip:

Spouse's/ Partner's Name:	Home Phone:
Middle Name:	E-mail Address:
Last Name:	Social Security #:
Address 1:	Race:
Address 2:	Marital Status:
City:	Date of Birth:
State:	Country:
Zip:	Age:
Employer:	Work Phone:
City:	Occupation:
State:	Zip:

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PATIENT REGISTRATION FORM 2 of 8

Nearest Relative (not living in same household)	Relationship:
Address 1:	Phone Number:
Address 2:	City:
State:	Zip

Referred By:	If Yellow Pages, (city Specific):
Doctor Name:	Phone Number:
Address 1:	Phone Number:
Address 2:	City:
State:	Zip:

Responsible Party (Complete Only If Different From Patient or Spouse)

Name:	Employed By:
Address 1:	Occupation:
Address 2:	Business Address 1:
City	Business Address 2:
State:	City:
Zip	State:
Home Phone:	Zip:
	Work Phone:

Primary Insurance Company	**Secondary Insurance Company**
Insurance Company	Insurance Company
Insured Name	Insured Name
ID Number	ID Number
Group Number	Group Number
Ph Number for Benefits:	Ph Number for Benefits:
Ph Number for Precerts:	Ph Number for Precerts:
Claim Mailing Address:	Claim Mailing Address:

PATIENT REGISTRATION FORM 3 of 8

Have you been referred to a particular physician?

If not, do you prefer a male or female physician?

If no referral or preference, would you be interested in
being scheduled with the first available physician?

Physician you are requesting an appointment with?

An administrative assistant will contact you during our regular office hours:
8:30 am – 4:00 pm, Monday – Thursday
8:30 am – 3:30 pm, Friday

At which number would you prefer to be contacted?

Please indicate the physician(s) from who you have requested medical records:

1. _____
2. _____
3. _____

Address(es) of physician(s):

1. _____
2. _____
3. _____

Main reason for seeking medical attention:

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PATIENT REGISTRATION FORM 4 of 8

Your present Age: Age at first period:

Weight: Height:

The interval between first day of one period to first day of next period ranges from _____ to _____ days.

Duration of flow is: Menstrual flow is usually:

Last menstrual period: Previous period:

Married: Length of Marriage:

Types of contraceptive(s) used & approximate dates: Length of time since last contraception:

Surgeries:

List all operations you have had with the date and place of surgery:

1. _____
2. _____
3. _____

Please list all infertility tests you have had in the past, with results if known:

1. _____
2. _____
3. _____

Dates of deliveries of pregnancies delivered over 5.5 pound birth weight:

1. _____ 2. _____

Dates of deliveries of pregnancies delivered over 1 pound and less than 5.5 pound birth weight:

1. _____ 2. _____

D&C or complications:

_____

_____

Number & dates of miscarriages: _____

Dates of therapeutic abortions: _____

Dates of tubal pregnancies: _____

Number of living children and dates of birth: _____

Number of adopted children and ages: _____

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PATIENT REGISTRATION FORM 5 of 8

Have you ever had the following?

Pain with periods	☐Yes	☐ No	**At other times:**	☐Yes	☐ No
Pain with sexual intercourse:	☐Yes	☐ No	**Sexual problems:**	☐Yes	☐ No
Herpes virus infection (genital):	☐Yes	☐ No	**Gonorrhea, Chlamydia, or Infection of tubes:**	☐Yes	☐ No
An abnormal Pap Smear:	☐Yes	☐ No	**High blood pressure:**	☐Yes	☐ No
Blood Transfusion:	☐Yes	☐ No	**Cancer:**	☐Yes	☐ No
Anemia:	☐Yes	☐ No	**Jaundice or hepatitis:**	☐Yes	☐ No
Bleeding disorder:	☐Yes	☐ No	**Gall bladder trouble:**	☐Yes	☐ No
Ulcer or gastrointestinal problems:	☐Yes	☐ No	**Blood clots or phlebitis:**	☐Yes	☐ No
Diabetes:	☐Yes	☐ No	**Heart murmur or lung:**	☐Yes	☐ No
Hernia:	☐Yes	☐ No	**Asthma or hayfever:**	☐Yes	☐ No
Arthritis, bone or joint problems Including injuries:	☐Yes	☐ No	**Kidney stones:**	☐Yes	☐ No
Convulsions:	☐Yes	☐ No	**Nervous breakdown or mental health**	☐Yes	☐ No
Varicose veins or blood clots:	☐Yes	☐ No			

If other, give explanation: _____

_____

Diagnosis and Year: _____

Please explain and include year of illness for any illness you answered yes to:

_____

_____

Have you ever been hospitalized for any non-surgical illness? _____

_____

Family History

	Age	Health	Age at Death	Cause
Father				
Mother				
Brother				
Brother				
Sister				
Sister				
Children				
Children				
Children				

Has any blood relative had any of the following?

Diabetes	☐Yes	☐ No	Cancer	☐Yes	☐ No
Birth Defects	☐Yes	☐ No	Down Syndrome or other Chromosomal Abnormalities	☐Yes	☐ No
Sickle Cell Disease	☐Yes	☐ No	Genetic Disorder	☐Yes	☐ No
Infertility	☐Yes	☐ No	Recurring Miscarriage	☐Yes	☐ No

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PATIENT REGISTRATION FORM 7 of 8

Check any of the following that you now have or which have been present in the last six months:

Headaches	❑	Lumps in breasts or Nipple discharge:	❑
Any problems of the eyes, ears, nose or throat	❑	Numbness or tingling	❑
Do you wear contacts or glasses	❑	Nausea or vomiting/ vomiting blood	❑
Do you have dentures which are removable	❑	Diarrhea	❑
Chronic cough or coughing blood	❑	Chest Pain	❑
Shortness of breath	❑	Swelling in hands, feet, ankles or calf tenderness	❑
Back pain	❑	Joint pain	❑
Hot flashes or sudden sensation of feeling hot	❑	Loss of consciousness, fainting or seizure	❑
Irregular or rapid heartbeat	❑	Anxiety or depression	❑
Weight gain or loss in past year _____lbs	❑		

Elaborate if needed:

Have you been tested for immunity to Rubella? ☐ Yes ☐ No

Did your mother take estrogen therapy during her pregnancy? ☐ Yes ☐ No

(For Black Patients)
Would you like to be tested for sickle cell disease? ☐ Yes ☐ No

(For Jewish Patients)
Would you like to be tested for Tay Sach's? ☐ Yes ☐ No

Drug reactions or allergies: Type of reaction:

Current medications:

Have you had sexual contact with a homosexual or bisexual person? ☐ Yes ☐ No

Have you had sexual contact with anyone using intravenous drugs? ☐ Yes ☐ No

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PATIENT REGISTRATION FORM 8 of 8

Education:

Religion:

Do you smoke? □ Yes □ No If yes, how many pack(s) per day?

Do you use alcohol? □ Yes □ No If yes, how much?

Do you exercise regularly? □ Yes □ No If yes, what type?

Any health problems in partner/husband:

Additional history no covered by above questions: _____

_____

_____

I hereby make assignment of all disability, surgical, medical and major insurance benefits to Carlene W. Elsner, M.D., Dorothy Mitchell-Leef, M.D., Michael A. Witt, M.D., Daniel B. Shapiro, M.D., Andrew A. Toledo, M.D., F.A.C.O.G., Scott M. Slayden, M.D., Robert J. Straub, M.D. and Pavna K. Brahma, M.D., to release any medical information necessary to execute an assignment of benefits. I understand that regardless of any insurance coverage I might have, I am personally responsible for all charges to this account. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be requested. I understand that I am responsible for services rendered and I agree to pay for services at the time of service. Insurance forms will be filed on hospital and surgery care only. I hereby authorize SOUTHEASTERN FERTILITY INSTITUTE and/or REPRODUCTIVE BIOLOGY ASSOCIATES to release any information acquired in the course of my examination and treatment to my insurance company or to another physician. I direct my insurance carrier to issue payment directly to SOUTHEASTERN FERTILITY INSTITUTE and/or REPRODUCTIVE BIOLOGY ASSOCIATES. I understand that I am financially responsible to SOUTHEASTERN FERTILITY INSTITUTE and/or REPRODUCTIVE BIOLOGY ASSOCIATES for any balance not covered by my insurance carrier. The cost of collection (30%) will be added to all delinquent accounts at the time they are placed with a collection agency.

_____ _____

Patient's Signature **Date**

_____ _____

Spouse/Partner's Signature **Date**

1/2009