Dear Patient:

Thank you for scheduling with Reproductive Medicine Associates of Philadelphia!

Your appointment has been scheduled with:

Martin Freedman, M.D.	_____
Arthur Castelbaum, M.D.	_____
Jacqueline Gutmann, M.D.	_____
Benjamin Gocial, M.D.	_____

Date: ____ Time: ________________

Office Address: (Please circle office)

Willow Grove
735 Fitzwatertown Rd.
Suite 2
Willow Grove, PA 19090
215.938.1515

King of Prussia
625 Clark Ave, Suite 17B
Suite 17B
King of Prussia, PA 19406
215.654.1544

Center City Philadelphia
1015 Chestnut St.
Suite 1500
Philadelphia, PA 19107
215.922.1556

Langhorne
320 Middletown Blvd.
Suite 303, The Courtyard
Langhorne, PA 19047
267.852.0780

Welcome to Reproductive Medicine Associates of Philadelphia

Enclosed are questionnaires for you to fill out and bring with you when you come in for your appointment. Please bring any relevant medical records with you as well. The consultation will last between 1 – 1 ½ hours. We request that both partners be present for the consultation if possible. An extensive history will be obtained as well as a complete physical exam on the female partner. You may also have blood work and ultrasound performed.

The physician that you see in consultation on that day will be your primary physician. You will design a plan for evaluation and treatment with that physician. The unique care plan created for you at the time of your consultation will be on file so that the entire medical team is aware of your treatment plan. During the course of your care, you may be seen by an RMA physician that is not your primary physician, a nurse practitioner or nurse. Your primary physician will be consulted on the findings of any visit and will be responsible for planning your care based on those results. We request that you call the office in which you are typically seen to schedule appointments or to direct questions.

You will meet with a financial counselor to review your insurance coverage. If your insurance requires referrals, please understand that it is your responsibility to obtain them. Co-pays are also due at the time of visit. Please have your insurance card(s), and a government issued form of identification with you at the time of visit. Please be advised that 24 hours notification is required for cancellation of an appointment. You will be responsible for payment of the consultation if appointment is cancelled anytime there after.

You may need to be seen on a weekend or holiday for either monitoring or an office procedure. All appointments are scheduled for late morning hours and are held at our King of Prussia office (625 Clark Ave., Suite 17B King of Prussia, PA 19406), and you will be seen by one of the physicians or nurses. During weekend visits, it may be necessary for blood to be drawn for hormonal monitoring. Results are available in the early afternoon. We request that on weekends you either be available for instructions by telephone between 11:00am and 2:00pm, or have a voicemail stating your first and last name where a detailed message can be left. The nurse will have discussed results with the on-call physician before calling you with instructions.

We welcome your questions and concerns and would like you to feel free to call during office hours to discuss them. There may be times when no one is available to speak to you when you call. If you leave a message, we will return your call. Quite often, telephone calls are returned in the afternoon.

Reproductive Medicine Associates of Philadelphia

Female Demographic Form

Doctor (please circle): Gocial Gutmann Castelbaum Freedman

Office you are being seen in today: Langhorne Willow Grove King Of Prussia Center City

Please have your insurance card and a government issued photo ID to present to Patient Services for copying.

Patient Name: ______________________________ Birth Date: ______________
Social Security Number: ______________________________ Marital Status: ______________
Home Address: ______________________________
City: ______________________________ State: ________ Zip: __________
Home Phone: ______________________________ Cell Phone: ______________
Work Phone: ______________________ Ext:______ Email: ______________
Employer: ______________________________ Occupation: ______________
Primary Care Physician: ______________________________ Tel#: ______________
OB/GYN: ______________________________ Tel#: ______________
Did your OB/GYN refer you to our Office: YES NO
IF NO, who referred you to RMA of Philadelphia: ______________________________
Emergency Contact: ______________________________ Relationship: ______________
Phone #: ______________________

Insurance Information

Insurance Company Name: ______________________________
ID#: ______________________________ Group#: ______________
Telephone Number: ______________________________
Does your insurance have an FSA/HSA/HRA?: __________ Remaining Balance: $ ______________
Subscriber Name: ______________________________ Subscriber Date of Birth: ______________
Social Security Number: ______________________________ Employer: ______________

I authorize Reproductive Medicine Associates of Philadelphia to release any information in the course of my examination or treatment to my insurance carrier(s). I further authorize any benefits due for services rendered to be paid directly to RMA of Philadelphia, Benjamin Gocial, MD; Jacqueline Gutmann, MD; Arthur Castelbaum, MD; or Martin Freedman, MD. I understand that I am responsible for any charges not covered by my insurance and for any balance due after insurance payments. If RMA does not participate with my insurance company, I also understand that payment MUST BE MADE AT THE TIME SERVICES ARE RENDERED.

Signature: ______________________________ Date: __________

ACKNOWLEDGEMENT OF RECEIPT OF REPRODUCTIVE MEDICINE ASSOCIATES OF PHILADELPHIA NOTICE OF PRIVACY PRACTICES

To be completed by female patient

By signing this document, I acknowledge that I have read and understand Reproductive Medicine Associates of Philadelphia's Notice of Privacy Practices.

Date: ________________________

Name (Print): ____

Signature: ____

I acknowledge that my care may require disclosures of my health information to the following, and I agree to such disclosures:

My Guardian/Parent: YES _____ Name: ____________________________ NO ______

My Spouse: YES _____ Name: ____________________________ NO ______

Other names:

Name: ____ Relationship: ________________

Name: ____ Relationship: ________________

For Reproductive Medicine Associates of Philadelphia's Use Only:

Date acknowledgement received: ___________________________

OR

Reason acknowledgement was not obtained and dates attempts made:

____

____

RMA of Philadelphia
Female Medical History

Name: ____ Date: ________________

Age: _____ Date of Birth: ________ Height: ________ Weight: ______ Ethnicity: _________________

Partner's Name: _______________________________________ Date of Birth: _____________

How long have you been trying to get pregnant (intercourse with no contraception)? ________ years

Length of Relationship: _____ years _____ months

How many times do you have intercourse? _____ per week ____ per month

Do you use lubricants for intercourse? (circle) YES NO

Do you have any sexual problems? ____

PCP: ________________________________ Gynecologist: __________________________

Referred by: ____

Other Physician(s): ____

PREVIOUS FERTILITY EVALUATION:

TEST	YES	NO	DATE PERFORMED	RESULT
Basal Body Temperature				
Ovulation Predictor Kit/Monitor				
Blood Tests				
Follicle Stimulating Hormone (FSH)				
Luteinizing Hormone (LH)				
Prolactin				
Thyroid Tests				
Estradiol				
Progesterone				
Testosterone				
Chromosomal Studies				
Anti-cardiolipin Antibodies				
Lupus Anticoagulant				
Other				
Ultrasound				
Hysterosalpingogram (HSG)				
Hysteroscopy				
Laparoscopy				
Endometrial Biopsy				
Post-coital Test				
Cervical Cultures				
Other				

PREVIOUS FERTILITY TREATMENT:

	# OF CYCLES	DOSE	DATES
Clomiphene (Clomid/Serophene) alone			
Intrauterine insemination (IUI) alone			
Clomiphene and IUI			
Gonadotropins (Gonal-F, Follistim, Menopur, Bravelle) alone			
Gonadotropins and IUI			
Progesterone			
GnRH agonist (Lupron)			
IVF (in vitro fertilization)			
Donor Eggs			
Donor Sperm			
Other			

GYNECOLOGIC HISTORY:

Date your last period began: ______________________

Do you skip months?: ___________________________

How may days does your period last?: ______________

Average # of days from 1st day to 1st day?: ______ days

Are your periods regular?: __________________

Do you bleed between periods?: ______________

Age at 1st period?: __________________________

Shortest interval: ________ days

Longest interval: ________ days

I have pelvic pain/cramps: (please check all that apply)

During menses ____ Before menses ____ After menses _____

Mid-cycle______ During intercourse _____ With urination _____

With bowel movements ___ None _____

My pelvic pain/cramps are: (please check all that apply)

Mild _____ Moderate _____ Severe _____ Getting worse ____ Improving ____

Not changing ____ On the right ____ On the left ____ In the middle ____

Medications taken for cramps/pain: ____

Contraceptives used:

Type	Date Used	Reason for Stopping

Date of last pap: _____________ Result: _____________________________________

Date of last mammogram: ___________ Result: _____________________________________

PREGNANCY HISTORY:

Total # pregnancies: _____
Term: _____ Preterm: _____ Miscarriage: _____ Abortion: ______ Ectopic: _____

Date	Type (Term, Preterm, Miscarriage, Abortion, Ectopic)	Vaginal or Cesarean	# of Months to conceive	Fertility Treatment?	Infant Wt. & Sex	Is Current Partner the Father?	Complications during pregnancy/delivery?

If miscarriage, was genetic testing done?: ____________ Results: _________________________________

MEDICAL HISTORY:

Do you have or have you had: (check all that apply)					
	Yes	**No**		**Yes**	**No**
Head Injury			Diabetes		
Seizures			Autoimmune Disease		
Migraines			Thyroid Disorders		
Asthma			Appendicitis		
Pelvic Infection			Colitis or enteritis		
Chlamydia			Endometriosis		
Gonorrhea			Pelvic adhesions		
Syphilis			Uterine fibroids or myomas		
Trichomonas			Uterine adhesions		
Mycoplasma			Abnormal uterus (shape)		
Ureaplasma			Ovarian cysts		
Genital warts/condylomata			Toxoplasmosis		
Genital Herpes			Cytomegalovirus (CMV)		
Recurring vaginitis			Chicken Pox		
Abnormal pap smears			Tuberculosis		
Cryo (freezing) or surgery of the cervix			Inheritable disorders		
Psychiatric treatment			Birth defects		

If you answered yes to any of the above, or you have any other medical problems, please describe:

____

____

____

SURGERY AND HOSPITALIZATIONS:

Date	Hospital	Diagnosis/Reason	Operation	Physician

MEDICATIONS:

Please list all prescriptions & over the counter drugs used currently

Medication	Dosage	Frequency	Dates Taken	Reason for Taking

ALLERGIES TO MEDICATIONS:

Medication	Type of Reaction

SOCIAL HISTORY:

	CURRENT			PAST		
	Yes	No	Amount	Yes	No	Amount
Smoking (packs per day)						
Alcohol (drinks per week)						
Caffeine (cups per day)						
Drug Use						
Toxic chemical exposure						
Radiation exposure						
Heat exposure						
Dietary restrictions						
Regular exercise						

FAMILY HISTORY:

ILLNESS	YES	NO	RELATIVE
Breast cancer			
Ovarian cancer			
Uterine cancer			
Colon cancer			
Cervical cancer			
Stroke			
Heart disease			
Diabetes			
High blood pressure			
Autoimmune disease			
Drinking problem			
Premature menopause			
Irregular menstrual cycles			
Infertility			
Recurrent miscarriage			
Endometriosis			
Birth defects			

REVIEW OF SYSTEMS:

Do you have, or have you recently had:					
	YES	NO		YES	NO
weight gain(>15 lbs)			leg cramps/burning		
weight loss (>15 lbs)			increased facial or body hair		
hot flashes			increased acne/oily skin		
poor sense of smell			breast discharge		
sinus problems			skin rashes, infections		
headaches			difficulty swallowing		
chest pain			indigestion/heartburn		
shortness of breath			nausea/vomiting		
ankle swelling			stomach pains		
palpitations			constipation		
blackout spells			diarrhea		
nervousness			jaundice		
chronic cough			frequent urination		
blood tinged sputum			blood in urine		
double/blurred vision			up at night to pass urine		
trouble with hearing or eyesight			prolonged fatigue		
bruising, anemia, swelling in glands			back trouble, joint pain, arthritis		

If you answered yes to any of the above or you have any other medical problems, please describe:

____

____

____

Please use the remainder of this page to explain any additional information you'd like to discuss.

____

____

____

____

____

____

____

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____

____

Completed By: Patient ____ Office Nurse _____ Physician _____

____

Patient Signature

______________________________________ ____________________________

Physician Signature Date Reviewed

Reproductive Medicine Associates of Philadelphia

Partner Demographic Form

Doctor (please circle): Gocial Gutmann Castelbaum Freedman

I am the patient's (please circle): Spouse Partner

Please have your insurance card and a government issued photo ID to present to Patient Services for copying.

Name: ______________________________ Birth Date: ______________

Social Security Number: ______________________________

Home Address: ______________________________

City: ______________________ State: ________ Zip: ______________

Home Phone: ______________________ Cell Phone: ______________________

Work Phone: ______________ Ext: _______ Email: ______________________

Employer: ______________________ Occupation: ______________________

Primary Care Physician: ______________________ Tel#: ______________

Have You Been Seen by a Urologist: YES NO

If Yes, Name of Doctor: ______________________ Tel#: ______________

Emergency Contact: ______________________ Relationship: ______________

Phone #: ______________________

<u>Insurance Information</u>

Insurance Company Name: ______________________________

ID#: ______________________ Group#: ______________________

Telephone Number: ______________________________

Does your insurance have an FSA/HSA/HRA?: ____________ Remaining Balance: $______________

Subscriber Name: ______________________ Subscriber Date of Birth: ______________

Subscriber SSN: ______________________ Subscriber Employer: ______________

I authorize Reproductive Medicine Associates of Philadelphia to release any information in the course of my examination or treatment to my insurance carrier(s). I further authorize any benefits due for services rendered to be paid directly to RMA of Phila, Benjamin Gocial, MD; Jacqueline Gutmann, MD; Arthur Castelbaum, MD; or Martin Freedman, MD. I understand that I am responsible for any charges not covered by my insurance and for any balance due after insurance payments. If RMA does not participate with my insurance company I also understand that payment MUST BE MADE AT THE TIME SERVICES ARE RENDERED.

Signature: ______________________________ Date: ______________

ACKNOWLEDGEMENT OF RECEIPT
OF REPRODUCTIVE MEDICINE ASSOCIATES OF PHILADELPHIA
NOTICE OF PRIVACY PRACTICES

To be completed by partner/spouse

By signing this document, I acknowledge that I have read and understand Reproductive Medicine Associates of Philadelphia's Notice of Privacy Practices.

Date: ________________

Name (Print) ____

Signature ____

I acknowledge that my care may require disclosures of my health information to the following, and I agree to such disclosures:

My Guardian/Parent: YES _____ Name: __________________________ NO ________

My Spouse: YES _____ Name: __________________________ NO ________

Other names:

Name: ____ Relationship: ______________

Name: ____ Relationship: ______________

For Reproductive Medicine Associates of Philadelphia's Use Only:

Date acknowledgement received: ___________________________

OR

Reason acknowledgement was not obtained and dates attempts made: ____________________

____

____

RMA of Philadelphia – Medical History - Male

Name: ____ Date: ____________________

Age: _____ Date of Birth: ________ Height: ________ Weight: ______ Ethnicity: __________________

Partner's Name: ____ Date of Birth: ______________

How long have you been trying to get pregnant (intercourse with no contraception)? ________ years

Length of Relationship: _____ years _____ months

How many times do you have intercourse? _____ per week ____ per month

Do you use lubricants for intercourse? (circle) YES NO

Do you have any sexual problems? ____

PCP: ____ Urologist: ________________________________

Referred by: ____

Other Physician(s): ____

SURGERY AND HOSPITALIZATIONS:

Date	Hospital	Diagnosis/Reason	Operation	Physician

MEDICATIONS:

Please list all prescriptions & over the counter drugs used currently

Medication	Dosage	Frequency	Dates Taken	Reason for Taking

ALLERGIES TO MEDICATIONS:

Medication	Type of Reaction

SOCIAL HISTORY:

	CURRENT			PAST		
	Yes	**No**	**Amount**	**Yes**	**No**	**Amount**
Smoking (packs per day)						
Alcohol (drinks per week)						
Caffeine (cups per day)						
Drug Use						
Toxic chemical exposure						
Radiation exposure						
Heat exposure						
Electric Blanket Use						
Dietary restrictions						
Regular exercise						

Do you have any problems with erection or ejaculation?: ____

Have you ever initiated a pregnancy with current partner?: YES NO

Another partner?: YES NO Age of Children: ________________________________

Do you have any inherited diseases in your family?: YES NO

Are there any birth defects in your family?: YES NO

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

	YES	NO		YES	NO
Chlamydia			Vasectomy (sterilization)		
Gonorrhea			Vasectomy Reversal		
Syphilis			Varicocele		
Genital Herpes			Varicocele repair surgery		
Genital warts/condylomata			Biopsy of testicles		
Mycoplasma			Hernia Surgery		
Ureaplasma			Abdominal surgery		
Urethritis/epididymitis			Cancer		
Prostatitis			High Blood Pressure		
Penile Discharge or pain			Diabetes		
Injury to the testicle(s)			Colitis		
Mumps with injury to testicles			Seizures		
			Psychiatric Treatment		

Have you had:

	RESULTS				
	Not Done	**Date**	**Normal**	**Abnormal**	**Values (if known)**
Semen Analysis					
Other Testing					

Have you undergone any fertility treatment?: YES NO

If YES, please list fertility evaluation/treatment information below

Date	Doctor	Treatment

Please use the section below for any additional information you feel the doctor may need to know.

____
____
____
____
____

Completed by: Patient ___ Partner ___ Office Nurse ___ Physician ___

Signature of Partner: ____

Physician Signature: ____

Date reviewed: __________________________

Family History and Genetic Questionnaire

Date: ___________
Patient Name: ______________________________ Partner Name: _______________________________

Please answer the following medical history questions about yourself, your partner and your relatives. Please consider all family members related to you or your partner by blood including parents, grandparents, siblings, half-siblings, nieces, nephews, aunts, uncles, cousins, and any children you have had together and/or with previous partners.

Have any of the following conditions occurred in your family? Check "yes" if the condition has occurred in you, your partner, and/or any of your relatives. Please specify how the person is related to you or your partner (for example, grandmother, aunt, son, etc) and any details you know about the condition. Additional space is provided below.	**Female and her family members**		**Male and his family members**	
	Yes ✓	Specify who in the family	Yes ✓	Specify who in the family
Open spine defect (e.g. spina bifida, anencephaly)				
Heart defect				
Cleft lip and/or palate				
Other birth defects				
Chromosome condition (e.g. translocation carrier, Down syndrome)				
Blood disorder (e.g. sickle cell anemia, thalassemia, hemochromatosis)				
Bleeding disorder (e.g. hemophilia)				
Neuromuscular disease (e.g. muscular dystrophy)				
Cystic fibrosis				
Adult onset neurological disorder (e.g. Huntington disease)				
Fragile X syndrome				
Other inherited or genetic condition				
Mental retardation				
Development delay, autism or learning difficulties				
Relative who died suddenly before age 50 years (not from accident)				
Kidney disease at a young age (before age 40 years)				
Cancer (before age 50 years)				
Three or more miscarriages				
A still born baby or a baby that died within the first year				
Premature menopause (before age 40 years)				
Infertility				
Any other family history that is of concern? (Please specify below)				

For any of the above answered "yes", please specify the condition. List who has the condition (you, your partner, or how they are related to you or your partner), the approximate age that the condition was diagnosed, and any details about the condition that you know:

____
____
____
____
____

Are you and your partner related by blood? (Circle) Yes No Unsure
If yes, how are you related? ____

Some genetic conditions occur more commonly in certain racial or ethnic groups.
Please answer the following questions about you and your partner's ethnic background, and any genetic testing, or carrier screening, either of you have had.

Ancestry: Female Partner

Are you, or any of your blood relatives… (Check all that apply)	Yes	Have you had carrier testing for…	No	Yes	Unsure	If you have had testing, when and what were the results?	
						Date	Result
Caucasian?		Cystic Fibrosis?					
From Italy, Greece, India or the Middle East?		Thalassemia?					
From Southeast Asia, Taiwan, China or the Philippines?		Thalassemia?					
African/African American or Hispanic?		Sickle-cell trait?					
French Canadian?		Cystic Fibrosis?					
		Tay-Sachs disease?					
Ashkenazi Jewish?		Cystic Fibrosis?					
		Canavan disease?					
		Tay-Sachs disease?					

Ancestry: Male Partner

Are you, or any of your blood relatives… (Check all that apply)	Yes	Have you had carrier testing for…	No	Yes	Unsure	If you have had testing, when and what were the results?	
						Date	Result
Caucasian?		Cystic Fibrosis?					
From Italy, Greece, India or the Middle East?		Thalassemia?					
From Southeast Asia, Taiwan, China or the Philippines?		Thalassemia?					
African/African American or Hispanic?		Sickle-cell trait?					
French Canadian?		Cystic Fibrosis?					
		Tay-Sachs disease?					
Ashkenazi Jewish?		Cystic Fibrosis?					
		Canavan disease?					
		Tay-Sachs disease?					

Have you or your partner had any genetic testing not listed above? (circle) Yes No Unsure

If yes, please specify who had the testing, what the test was for, and the result:

Name	Date of Testing	Name of Test	Test Result

Please read the following paragraphs, then sign and date.

Reproductive Medicine Associates of Philadelphia

It is our office policy to bill your insurance carriers as a courtesy to you for all office, lab, and surgical services rendered. This policy in no way alleviates your responsibility for payment in full should your insurance deny billed services. All non-covered patient services-- such as office visits or supplies-- are payable at each visit. Any remaining balances after your insurance carrier has paid will be due in full from you within 30 days unless other arrangements have been made by our billing department.

I have read, understood, and agreed on the above policies of Reproductive Medicine Associates of Philadelphia.

Signature: ____ Date: ____________________

Patient's Certification and Authorization to Release Information and Payment Request

I hereby authorize Reproductive Medicine Associates of Philadelphia to submit any claims to my insurance carrier or intermediaries for all covered services rendered. Also, I authorize and direct my insurance carrier or its intermediaries to issue payment directly to Reproductive Medicine Associates of Philadelphia.

I authorize Reproductive Medicine Associates of Philadelphia to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

Signature: ____ Date: ____________________

REPRODUCTIVE MEDICINE ASSOCIATES OF PHILADELPHIA

Board Certified Reproductive Endocrinology and Infertility
Martin F. Freedman, M.D. FACOG
Arthur J. Castelbaum, M.D. FACOG
Jacqueline N. Gutmann, M.D. FACOG
Benjamin Gocial, M.D. FACOG

SEND THIS RELEASE FORM TO YOUR PREVIOUS OB/GYN DOCTOR OR OTHER PHYSICIAN(S)

To: ____
Previous Doctor's Name

I hereby authorize and request that you release my complete medical records to:

_____ Martin F. Freedman, M.D.

_____ Arthur J. Castelbaum, M.D.

_____ Jacqueline N. Gutmann, M.D.

_____ Benjamin Gocial, M.D.

My appointment is scheduled on ______________________ at the ________________________________ office.
Date Office Location

Please find office contact information below. Thank you for your prompt attention.

Patient Name (Print) Signature

Patient Date of Birth Address

City State Zip Code

Willow Grove
735 Fitzwatertown Road, Suite 2
Willow Grove, Pa. 19090
TEL: (215) 938-1515
FAX: (215) 938-8756

King of Prussia
625 Clark Ave., Suite 17B
King of Prussia, PA 19406
TEL: (215) 654-1544
FAX: (215) 654-1543

Center City Office
1015 Chestnut St., Suite 1500
Philadelphia, PA 19107
TEL: (215) 922 -1556
FAX: (215) 922- 1565

320 Middletown Blvd.
Suite 303
Langhorne, Pa. 19047
TEL: (267) 852-0780
FAX: (267) 852-0786