Valley
Andrology
Fertility Center

Patient Information

PATIENT INFORMATION

Last Name	First Name	Middle Name	
Date of Birth	Sex ☐ M ☐ F	Social Security #	Marital Status ☐ Single ☐ Widowed ☐ Separated ☐ Married ☐ Divorced	Age
Home Street Address	City and State	Zip Code	
Mailing Street Address	City and State	Zip Code	
Home Phone ( )	Cell Phone ( )	Drivers License #	Exp Date
Employer or School	Address	Occupation	
Emergency Contact Person	Emergency Contact's Phone ( )		

SPOUSE

Spouse's Last Name	First Name	MI	Date of Birth
Spouse's Employer	Address	City and State	Zip Code
Phone ( )	Occupation	Drivers License	

REFERRING PHYSICIAN(S)

Referring Physician	Referring OB/GYN
Referring Physician's Address	Referring OB/GYN's Address
Referring Physician's Telephone Number	Referring OB/GYN's Telephone Number

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WELCOME TO OUR PRACTICE

We appreciate your appointment and we pledge to provide you with the highest quality medical care. Please read the following information to ensure the best possible experience for you here in our office. Please do not hesitate to discuss any questions or concerns that you may have.

PRIVACY

We make every effort to protect your privacy and maintain personalized health care information in a confidential manner. Valley Andrology Fertility Center (VAFC) has a Health Insurance Portability and Accountability Act (HIPAA) office policy in place, which describes how your protected health information may be used and disclosed and how you can obtain access to this information. Any request for medical information must be made in writing.

I authorize VAFC to discuss medical information related to my care to the following family members. Only those listed here will be authorized:

Name _____Relationship_____

Name _____Relationship_____

Patient Signature: _____

Date: _____

SPECIALISTS

We specialize in Male Reproductive Endocrinology and Infertility. We are not primary care providers; therefore it is important that you have a relationship with a primary physician to provide ongoing health care.

PROVIDERS

Thomas X. Minor, MD, Nadeem Rahman, MD, Greg Rainwater, MD, Carlos Sueldo, MD and Michael Synn, MD work together to provide medical care for our patients at Valley Andrology Fertility Center. You may be scheduled with either of these physicians for your consultation and/or services provided at VAFC. If you have a personal preference we will try to accommodate if at all possible.

INSURANCE / PAYMENTS

Payment in full is expected at the time of service. For your convenience VAFC accepts cash, check, Visa and MasterCard. However, due to the nature of our business we are not contracted with any insurance companies. We will gladly provide you with an itemized statement for you to bill your insurance company for reimbursement. In addition any storage of samples will incur a yearly storage fee or as an alternative we will set up automatic debit/credit withdrawals.

CANCELLATION OF SCHEDULED APPOINTMENTS

We realize that unforeseen circumstances might make it impossible for you to keep your appointment. If this should occur, we ask that you kindly call our office 24 hours prior to your appointment and reschedule for a more convenient time. Should a patient fail to cancel a previously scheduled appointment, he will be notified by our office and reminded of our policy. If the patient should fail two appointments without canceling, he will be charged a $ 25.00 fee for a failed appointment. Your insurance carrier will not cover this charge. After payment of the cancellation fee, you will be rescheduled at the next available opening. If you continue to fail appointments, you may be dismissed from the practice and will need to seek medical care from another facility.

OUTSIDE PROVIDERS

Many insurance companies require that you use a specific laboratory, radiologist, pharmacy or other contracted specialist. We are familiar with the requirements of some insurance companies and will make a good faith effort to direct you the best that we can but it is ultimately your responsibility to understand your level of coverage and which contracted facilities you must use. It is your responsibility to determine which outside providers are contracted with your insurance.

TELEPHONE CALLS

All of our office staff and providers are qualified and experienced in answering your calls and addressing your medical needs. Our staff will be able to answer routine questions for you. However; in general, non-emergency concerns should be addressed at a scheduled office visit. Emergent calls will be taken by our staff or the telephone exchange service and directed to the appropriate provider. If you have a life threatening emergency please call 911.

AFTER HOUR SERVICES

Our practice offers a very specialized service and as such only our physicians can provide our patients the majority of their care needs. Our physicians will respond to after hours emergent patient needs however we ask that you please use reasonable judgement when determining what is urgent and what is routine when calling for after hour care.

MEDICAL RECORDS

Our office will copy your medical records upon request and after signing a Release of Medical Information form. The fee for copying your records is $25.00. All requests for medical records must be made in writing. We will not release medical records to any patient or family member without consent from the patient. It is our policy to respond to these requests within 15 working days.

HEALTHY CHOICES

We want to work with you to help you make healthy and beneficial choices. You have the right to decline any medical therapies or evaluations that we might discuss.

Tobacco use has been shown to decrease sperm function. Moreover, it is simply harmful to your overall health. Smoking is not allowed in our office at any time.

Please enjoy your food or beverage outside of the office. Staining of carpet and furniture is an unsightly and expensive consequence of spilled drinks.

We strive to offer you excellence in both medical and personal care in an atmosphere of comfort and mutual respect. As we respect you, we ask that you respect our staff and other patients by complying with our policies.

Please do not hesitate to speak to any member of our staff if you have any questions regarding these policies.

THANK YOU FOR CHOOSING VALLEY ANDROLOGY FERTILITY CENTER!

I have read and understand these policies.

Patient Name (please print):

_____

Patient Signature:

_____

Date: _____

Valley Andrology Fertility Center

NEW PATIENT QUESTIONAIRE

PATIENT NAME	DATE OF BIRTH

Reason for today's appointment :

- ☐ Complete Semen Analysis
- ☐ Post Vasectomy Semen Analysis
- ☐ Other :
- ☐ Cryopreservation
- ☐ IUI Wash

Time Sample Collected : _____

Was any portion of the sample lost during collection? Y N Days of Abstinence: _____

IF YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE EXPLAIN ON REVERSE

	Y	N
DIABETES	☐	☐
HIGH BLOOD PRESSURE	☐	☐
HEART FAILURE	☐	☐
HEART ATTACK	☐	☐
ANGINA/CHEST PAIN	☐	☐
HEART MURMUR	☐	☐
RHEUMATIC FEVER	☐	☐
TUBERCULOSIS	☐	☐
ASTHMA	☐	☐
PNEUMONIA	☐	☐
ULCER PROBLEMS	☐	☐
COLON DISORDERS	☐	☐
HEMORRHOIDS	☐	☐
HEPATITIS	☐	☐
JAUNDICE	☐	☐
BLEEDING PROBLEMS	☐	☐
GASTROINTESTINAL BLEEDING	☐	☐
EASY BRUISING	☐	☐
ARTHRITIS	☐	☐
KIDNEY FAILURE	☐	☐
KIDNEY STONES	☐	☐
URINARY TRACT INFECTION	☐	☐
PROSTATE DISORDERS	☐	☐
TEMPORARY BLINDNESS	☐	☐
DIFFICULTY WALKING	☐	☐
STROKES	☐	☐
WEAKNESS OR NUMBNESS OF PARTS OF YOUR BODY	☐	☐
CANCER	☐	☐
PROSTHETIC DEVICES	☐	☐
DO YOU TAKE ANTIBIOTICS FOR DENTAL APPOINTMENTS	☐	☐

Current medications: (dose and frequency)

Allergies: (penicillin, iodine, sulfa, etc.)

Family History:

	YES	NO	Whom?
DIABETES	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	
HEART DISEASE	☐	☐	
CANCER (TYPE)	☐	☐	

Surgical History:

Previous Diagnostic Procedures or Tests (& dates)

Tobacco Use? If Yes, how much?

Alcohol?
Never Seldom Socially Frequently

COMPLETED BY	DATE

Revised 7/10/2020