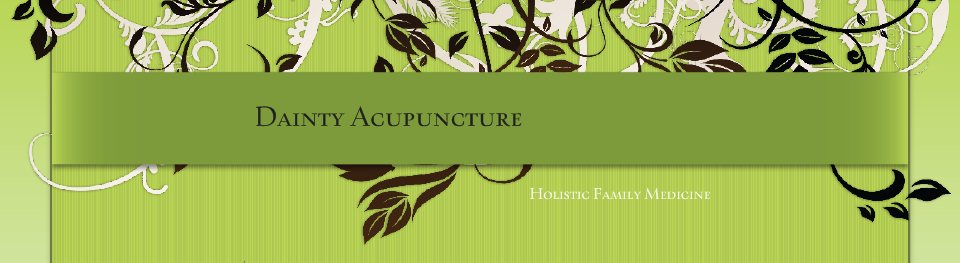


Patient Information

|  |
| --- |
| First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_  Gender M F Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­  Married □ Single □ Domestic Partner □  Name of Spouse/Partner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | |  | |



**Male Fertility Questionnaire**

Name (Last, First, Middle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**Western Diagnosis**

Name of your Fertility Specialist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date MO/YR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Results for Semen Analysis:

Date\_\_\_\_\_\_\_\_ Count\_\_\_\_\_\_\_\_\_ Morphology\_\_\_\_\_\_\_\_\_\_\_ Motility\_\_\_\_\_\_\_\_\_\_\_ Volume\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_ Count\_\_\_\_\_\_\_\_\_ Morphology\_\_\_\_\_\_\_\_\_\_\_ Motility\_\_\_\_\_\_\_\_\_\_\_ Volume\_\_\_\_\_\_\_\_\_

2. Do we have a copy of your Semen Analysis? Y / N

3. Other Procedures/ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Varicocele Vasectomy Vasectomy Reversal Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Please list Medications/Supplements/Vitamins you are currently taking?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other**

5. Couples ART Plans:

IUI Clomid IVF PGD Donor Egg Surrogate Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Have you fathered children Y / N If so, how many \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Please circle all that apply to your PAST medical history:

Infection Chlamydia Erectile Dysfunction Ejaculation Problems Retrograde Ejaculation Prostate Cancer BPH

Anti-sperm Antibodies Sperm Chromatid /DNA Integrity High Cholesterol Diabetes

Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Please circle all that apply to your CURRENT medical condition:

Infection Chlamydia Erectile Dysfunction Ejaculation Problems Retrograde Ejaculation Prostate Cancer BPH

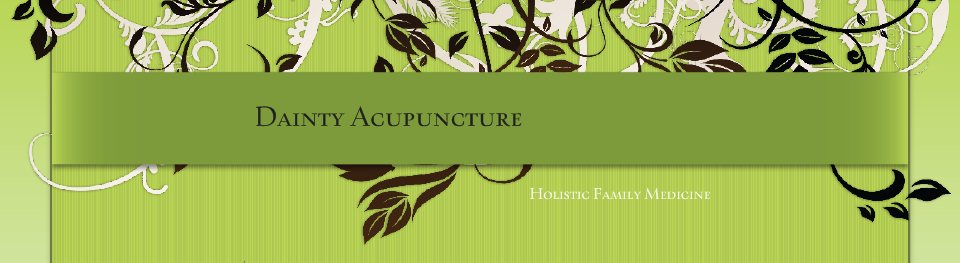
Anti-sperm Antibodies Sperm Chromatid /DNA Integrity High Cholesterol Diabetes

Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Is your Spouse currently being treated by us? Y / N

10. Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Western Diagnosis of Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Dainty Acupuncture (DA), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

We will not release this information unless we receive a subpoena or an Authorization to Release Records signed by you.

DA may call my home or other designated location and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance information, and any call pertaining to my clinical care.

DA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements marked Personal and Confidential.

DA may email me appointment reminders and patient statements.

I have the right to request that DA restrict how it uses or discloses my PHI to carry out TPO. By signing this form, I am consenting to DA use and disclosure of my PHI to carry out TPO.

I may revoke my consent at any time in writing. If I do not sign this consent, DA may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

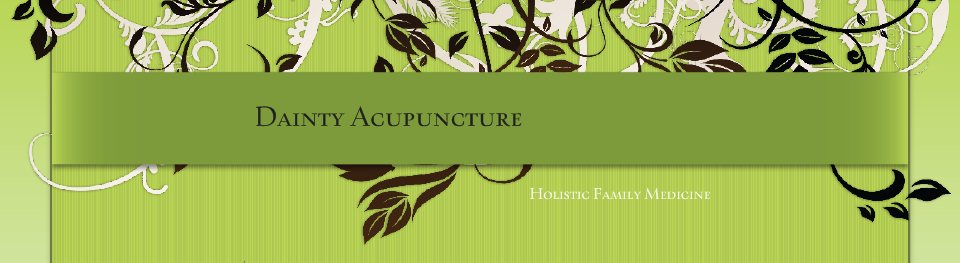
Signature of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date



**Terms and Conditions of Service**

Acupuncture Information and Guidelines

Acupuncture is designed to naturally balance, heal, and rejuvenate the body. In order to fully absorb and integrate the benefits of your treatment, avoid strenuous activity or stressful situations for the remainder of the day. Please drink plenty of water after your treatment. Please inform your practitioner of any sensitivities, injuries, or transmittable diseases to ensure your safety, and the safety of your practitioner.

Office Policies

Cancellations and rescheduling of appointments must be done at least 24 hours in advance. You will be charged the full price of your service for any cancellations made less than 24 hours before the scheduled appointment. A bill will be mailed to the address you provided to us. A $25.00 fee will be charged for any returned checks. Returned checks must be replaced by a secured form of payment (credit card or cash). Payment is due when services are rendered. By signing below, you authorize the release of any information necessary to your insurance company in order to process your claim. Should accounts be referred to an attorney or collection agency, attorney’s fees and collection expenses incurred shall be payable in addition to the other previous amounts due.

Medical Records

Dainty Acupuncture will not release your records to anyone unless you have signed the “Release of Records” form, or we are instructed to do so by a subpoena or your insurance company. You give Dainty Acupuncture permission to obtain medical records from previous physicians or medical centers.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date