DVIF&G
Delaware Valley Institute of Fertility & Genetics
Success Through Assisted Reproductive Technologies START
6000 Sagemore Drive, Suite 6102, Marlton, NJ 08053
856-988-0072 • Fax: 856-988-0056

Patient Registration Form

Date: _____

EMAIL ADDRESS: _____

Last Name	First Name	M.I.

Street address	City	State	Zip

SS#	Home Phone	Work Phone

Patients Cell Phone	Ethnic Background (*i.e. Irish, Italian, etc.*)

Permission to call patient at work ☐ Yes ☐ No	Permission to leave message on machine ☐ Yes ☐ No	Date of Birth	Age

Sex ☐ Female ☐ Male	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated	☐ Caucasian ☐ Asian ☐ Other ☐ African American ☐ Hispanic

Occupation	Employer

Work Address

Partner's Last Name	First Name	M.I.

SS#	Ethnic Background (*i.e. Irish, Italian, etc.*)	Date of Birth	Age

Employer	Cell Phone	☐ Caucasian ☐ Asian ☐ Other ☐ African American ☐ Hispanic

Work Address	Work Phone

Primary Insurance Co.	Subscriber	Is spouse covered under this plan? ☐ Yes ☐ No

ID	Group #	Effective Date

Secondary Insurance	Subscriber

ID	Group #	Effective Date

OB/GYN Physician (if applicable) Name and Address	Phone Number

Primary Family Practice Physician Name and Address	Phone Number

Pharmacy	Phone Number

Prescription card, *if separate from insurance card.*

How did you hear about Delaware Valley Institute of Fertility & Genetics

I give DVIF&G permission to speak with spouse/partner about my test results. ☐ Yes ☐ No

I hereby authorize Delaware Valley Institute of Fertility & Genetics to furnish information to insurance carriers concerning my illness and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I accept responsibility for complete payment of my medical bills.

_____ Signature of Patient

_____ Date

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Consent Form

During my evaluation and treatment at Delaware Valley Institute of Fertility & Genetics (DVIF&G), a number of procedures, laboratory tests, toxicology/ genetic screening and/or testing, X-rays, ultrasounds, and clinical examinations will be performed. Information collected through those tests is essential for diagnosis and treatment or for exclusion of any underlying medical problem(s) or condition(s). This information will become my permanent medical record. The authorized physician(s) and staff of DVIF&G and I will have access to this record and only with my consent will this information be made available to any authorized party.

_____ (Initials)

During your evaluation at DVIF&G, genetic tests may be ordered. Genetic conditions can occur spontaneously so that you are the only one in your family that is affected. However, you may inherit the condition from your parents. If your genetic test is abnormal, **YOU HAVE TO NOTIFY** your family members, as they may have the same condition. Some of the genetically inherited conditions may require further evaluation and possible treatment to safeguard health and well being.

_____ (Initials)

I understand that my insurance carrier and its lawfully designated representatives or other state or federal agencies, as the law provides, can obtain and review my medical record without any previous authorization by either my physician or me. I also understand that data collected through my evaluation and treatment will be used separately and collectively with those obtained from other patients and without any personal identification of any kind for quality assurance, quality control, clinical research, evaluation of effectiveness of treatment, assessment of treatment methods, and the like, as deemed necessary. Any biological samples, such as urine, blood, serum, and/or semen obtained in the course of my evaluation and treatment, after the intended biochemical or biological measurement are completed, will be disposed of according to the rules and regulations provided by OSHA for medical, infectious and biohazardous waste or will be used separately and collectively with those obtained from other patients and without any personal identification of any kind for quality assurance, quality control, clinical research, evaluation of effectiveness of treatment, assessment of treatment methods, and the like, as deemed necessary. A complete copy of the Notice of Privacy Practice is available on our website or may be obtained upon request.

_____ (initials)

I understand that my treatment may require blood work. These labs may consist of infectious labs including, but not limited to, Hepatitis, HIV, RPR, and any genetic testing which may include, but not limited to, Karyotype and Cystic Fibrosis. I agree to the insertion of a peripheral blood collection device by a trained professional. I realize that this is an invasive procedure and has certain risks such as infection, bruising, vein inflammation, and nerve damage.

_____(initials)

I am not legally married to someone other than the person with whom I am seeking fertility treatment in your office. I understand that If I am married to someone else, I will be required to obtain additional legal documentation prior to fertility treatments, and all ongoing treatment will be suspended.

_____(initials)

I agree that upon making an appointment with DVIF&G, I will take responsibility to keep that appointment. If I am unable to keep the appointment, I will call DVIF&G no later than 24 hours prior to the appointment to cancel and reschedule the appointment. If I provide DVIF&G with less than 24 hours notice of a cancellation, they have the right to charge me $50.00 for the empty time slot. _____ (initials)

I, _____, ☐ **do** give / ☐ **do not** give Delaware Valley Institute of Fertility & Genetics permission to speak with _____ about my test results.

_____ Signature

I, _____, ☐ **do** give / ☐ **do not** give Delaware Valley Institute of Fertility & Genetics permission to share my medical information with any of my referring physicians.

_____ Signature

I hereby certify that I have read and understand the information included in this consent form.

_____ Print Name

_____ Print Name

_____ Patient Signature Date

_____ Witness Signature Date

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INFORMED CONSENT/REFUSAL FOR GENETIC TESTING

1. I am a patient of the Delaware Valley Institute of Fertility & Genetics (hereinafter DVIFG).

2. I understand that DVIFG seeks to perform certain genetic DNA tests to look for mutations, specifically autosomal recessive or x-linked genetic conditions. Mutations are often different in different populations. I understand that DVIFG needs accurate information about my family history and ethnic background.

3. When DNA testing demonstrates a mutation, the person is a carrier or is affected with that condition or disease. Consulting a doctor or genetic counselor is recommended to understand the full implications of the results.

4. When the DNA testing does not show a known mutation, the chance that the person is a carrier or is affected is reduced. **There is still a risk to be a carrier or to be affected because current testing cannot find all the possible changes within a gene.**

5. In some families, DNA testing might discover non-paternity (someone who is not the biological father) or some other previously unknown information about family relationships, such as adoption.

6. The decision to consent or refuse to consent to the genetic DNA testing is entirely mine.

7. DVIFG will not perform any test except the ones authorized by my doctor. Any unused portion of my original sample will be destroyed within 2 months of receipt. DVIFG will disclose the test results ONLY to the doctor named below, or to his/her agent, unless otherwise authorized by the patient or required by law.

8. My signature below indicates that I have read, or have read to me, the above information. I understand it. I have had the opportunity to discuss this information, including the purposes and possible risks, with my doctor or someone my doctor designated. I understand that I may obtain professional genetic counseling if I wish before signed this consent. I have all the information I want. All of my questions have been answered.

____ **YES** I REQUEST that DVIF&G performs the genetic testing. I understand and accept the consequences of this decision.

____ **NO** I DECLINE to have the genetic testing offered to me. I understand and accept the consequences of this decision.

Date:_____ _____ _____
Print Patient Name Sign Patient Name

Date:_____ _____ _____
Print Witness Name Sign Witness Name

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STRESS MANAGEMENT AT DVIF&G

The effect of stress on reproduction have been well documented. Stress levels amplify during infertility treatment. We are dedicated in our practice to remove the cycle of stress in order to achieve your goals of fertility sooner.

You can help accelerate your process of treatment by filling out this simple stress test. Evaluate the results yourself. Your doctor will assist you with interpreting these results after all your medical tests have been completed. This tool will help us create a program of treatment to fit your specific needs. If appropriate, counseling services will be made available to you. Karen Ann Brook, LCSW, is our social worker who can help you navigate through the maze of infertility toward achieving your goal.

The staff at DVIF&G has your success as our focus. All aspects that contribute to the problem of infertility are addressed and no effort is spared for a successful outcome.

Name _____ Partner Name _____ Date_____

Please check the box which best describes how well you are doing in your marital/significant other relationship.

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Applicable	Cannot Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Please check the box which best describes how well you are doing in your family relationships.

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Applicable	Cannot Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Please check the box which best describes how well you are doing in relationships with people outside your family.

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Applicable	Cannot Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Please check the box which best describes your current physical health.

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
Very Poor									Excellent

Please check the box which best describes your general happiness and well-being.

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
Very Poor									Excellent

Please check the box which best describes how well you are doing on your job.

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Working	Cannot Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Please rate how much you were affected by the following in the week before your first appointment:

	Extreme	Severe	Moderate	Mild	None
Concerns about your body or physical health	☐	☐	☐	☐	☐
Thoughts or behaviors you do over and over again	☐	☐	☐	☐	☐
Unusually high energy	☐	☐	☐	☐	☐
Feeling sad, blue, or depressed	☐	☐	☐	☐	☐
Anxiety, nerves, or tension	☐	☐	☐	☐	☐
Anger, hostility, or irritability	☐	☐	☐	☐	☐
Fears of things or places	☐	☐	☐	☐	☐
Beliefs that others want to hurt you	☐	☐	☐	☐	☐
Drinking too much or drugs	☐	☐	☐	☐	☐
Unreal, strange, or “bizarre” thoughts	☐	☐	☐	☐	☐

COMMENTS (For office use only)

_____

_____

_____

_____