WEST COAST FERTILITY CENTERS
SCIENCE. SOLUTIONS. SUCCESS!
www.IVFBABY.com

DAVID DIAZ, MD, FACOG
Egg Freezing & Infertility Specialist

Patient Registration Form

Today's Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ Gender F M Date of Birth _____

Address _____ City _____ State _____ Zip Code _____ Preferred Language _____

Email Address _____ Drivers License # _____ Social Security # _____

Home Phone _____ What is the best number to contact you? _____

Cell Phone _____ Occupation _____ Employer _____

Work Phone _____ Work Address _____ City _____ State _____ Zip Code _____

PATIENT MARITAL STATUS

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed Gender F M Date of Birth _____

Partner's Last Name _____ First Name _____

Cell Phone _____ Work Phone _____ Occupation _____

Address _____ City _____ State _____ Zip Code _____ Preferred Language _____

Email Address _____ Drivers License # _____ Social Security # _____

EMERGENCY CONTACT

Last name _____ First Name _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____ Cell Phone _____

INSURANCE INFORMATION

Name of Insurance _____ Insurance ID # _____ PPO or HMO _____

Provider _____ Customer Service Phone Number _____

REFERRAL SOURCE - How did you hear about us?

◯ Family/Friend _____ Name ◯ Physician _____ Name

◯ Google ◯ Yahoo ◯ Bing ◯ AOL ◯ Press Release ◯ Other _____

FOR OFFICE USE ONLY

Date: Account # Data Entry By:

West Coast Fertility Centers
Patient Rights & Responsibilities

PATIENT RIGHTS:

We respect the rights of our patients and recognize that each person is an individual with different needs. To the extent possible, we will provide:

1. Equitable, unbiased, considerate and respectful care by competent personnel in a safe environment.
2. Treatment without discrimination as to your race, age, religion, sex, sexual orientation, national origin, ability to pay, or illness. Patients are provided appropriate privacy regarding medical records and during interviews, examination, treatment, and consultation. Be assured you will receive physical privacy that is appropriate to the medical care. Medical information will not be released without patient's written consent.
3. The opportunity to participate in decisions involving your health care.
4. Complete and current information concerning your diagnosis, treatment and prognosis to you or your designee.
5. Informed consent process for any and all treatments and procedures (with the exception of emergency medical care). The informed-consent process includes an explanation of the treatment or procedure; any alternative treatments or procedures; the intent, and possible complications of the treatment or procedure; and the anticipated outcome.
6. Complete and adequate discharge instructions after treatment to insure continuity of care.
7. Explanation of the cost for testing and treatment and explanation of your bill.
8. The opportunity to submit any concerns in writing and to receive an appropriate response.
9. The opportunity, if you wish, to formulate advance directives and appoint someone else to make health care decisions to the extent permitted by law.

PATIENT RESPONSIBILITIES:

Prospective patient have certain responsibilities to ensure we are prepared to offer the care you need.

1. Cooperate with the physicians and healthcare providers. All prospective patients, male or female, treated at WCFC must disclose any current or past medical condition including the use of prescription medications, illicit or recreational drugs, rehabilitation treatments, psychiatric conditions, drug addictions past or present. Provide our physicians and staff with a complete and honest history about illnesses, hospitalizations, medications and other matters related to your health. Please be truthful accurate in all information you provide us.
2. All persons undergoing testing or treatment at WCFC must present a current, valid, government issued photo identification which must be acceptable to the administrative staff.
3. All patients must be compliant with statutory reproductive regulations in California.
4. All patients must conduct themselves in a professional manner, treating WCFC staff with respect and courtesy. WCFC reserve the right to terminate service to any patient by providing 30 days notice.
5. You are expected to arrive promptly for appointments or provide timely notice when canceling.
6. Please be patient when an appointment is delayed; keep in mind that an emergency may be taking place.
7. All financial obligations must be met before any treatment can be started. If unsure, please ask.
8. Notify WCFC if there is any problem or dissatisfaction with care or services.
9. Patients with children are asked to respect the feelings of those who are struggling with infertility. Kindly make arrangements for childcare in your home.
10. Everyone's time is valuable. When cancelling an appointment, we require 48 hours to avoid a $100 fee.

Name **Signature** **Date**

DAVID G. DIAZ, M.D., Inc.
PRIVACY & FINANCIAL AGREEMENT

Thank you for selecting West Coast Fertility Centers for your Specialized Treatment.
To insure confidentiality, we will only report test results to you or your designee.

Please give us directions on how you would like to receive test results.

☐ **Patient Home #** _____ ☐ **Cell #** _____

☐ **Partner Home #** _____ ☐ **Cell #** _____

RESULTS AND RECOMMENDATIONS MAY BE REPORTED TO:

BOTH PARTNERS ◯ **YES** ◯ **NO**

If no, please indicate the name and phone numbers of the person you wish to receive the test results.

_____

Name **Home Number** **Cell Number**

Do you have an Advanced Directive? ◯ **Yes** ◯ **No**

If yes, please provide a copy to our office. West Coast Fertility Centers **will honor** Advanced Directives of the patient's choice.

FINANCIAL AGREEMENT: I authorize David G. Diaz, M.D., Inc. and staff to undertake testing recommendations and treatment. I understand I may ask questions about my testing, treatment, risks, complications and treatment options.

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full AT THE TIME OF SERVICE, unless other arrangements are made in advance with the business office. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I agree to take responsibility of any and all costs incurred for services rendered. If surgery is required, I authorize any payment of medical benefits to DGD M.D. Inc. I understand that any outstanding payment regardless of insurance payment is my responsibility. A photocopy of this signature is as valid as the original. I also authorize the physician to release any information required in processing of insurance claims.

I have received a copy of the patient rights and responsibilities.

_____

Patient Signature **Printed Name** **Date**

_____

Partner Signature **Printed Name** **Date**

DAVID G. DIAZ, M.D., Inc.
PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

ARTICLE 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitrat ion shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the Intervention and joinder in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.5; however, depositions may be taken without prior approved of the neutral arbitrator.

ARTICLE 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California stature of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

ARTICLE 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

ARTICLE 6: **Retroactive Effect**:This agreement will cover services rendered before the date it is signed (including, but not limited to, emergency treatment). If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provision shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____

Patient's or Patient Representative Signature **Date**

_____

Print Patient's Name (If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the patient. Original is to be filed in patient's medical records.

David G. Diaz, MD, Inc. _____

Physician's or Authorized Representative's Signature **Date**

West Coast Fertility Centers
New Patient Intake Form

	OFFICE STAFF USE	
	B/P : _____	GRAV : _____
	LMP : _____	PARA : _____
	CD : _____	SAB : _____
	Wt : _____	TAB : _____
	BMI : _____	ECTOPIC : _____

PATIENT HISTORY

FEMALE NAME: _____

AGE: _____ HEIGHT: _____ ETHNICITY: _____

LIST ANY MEDICATIONS YOU HAVE ALLERGIES TO & YOUR REACTIONS: _____

_____

_____

LIST ALL MEDICATIONS YOU ARE TAKING CURRENTLY: _____

_____

_____

YEARS WITH PARTNER? _____ YEARS OF UNPROTECTED SEX? _____ PROVEN? ☐ Present Partner ☐ Previous Partner

LIST ANY COMPLICATIONS DURING PREGNANCIES OR DELIVERY: _____

_____

_____

GYNECOLOGIC HISTORY

ONSET OF MOST RECENT MENSTRUAL PERIOD? _____

HOW MANY DAYS DO PERIODS LAST? _____

HOW MANY DAYS FROM THE START OF ONE PERIOD TO THE NEXT? _____

LEVEL OF PAIN (0 - 10): _____

IS IT PAINFUL DURING INTERCOURSE? _____

LAST PAP SMEAR (Date / Result): _____

MEDICAL HISTORY

PLEASE EXPLAIN ANY MEDICAL CONDITIONS YOU HAVE: _____

_____

_____

PLEASE LIST AND DATE ALL PAST SURGERIES AND/OR PROCEDURES (Major & Minor): _____

_____

_____

OCCUPATION: _____ STRESS LEVEL: _____

EXERCISE (Type / How Often): _____

DO YOU SMOKE? _____ IF YOU SMOKE, HOW MANY CIGARETTES PER DAY? _____

DO YOU DRINK? _____ IF YOU DRINK, HOW MANY ALCOHOLIC DRINKS PER DAY? _____

FAMILY HISTORY

HOW MANY BROTHERS DO YOU HAVE? _____

HOW MANY SISTERS DO YOU HAVE? _____

DO YOUR SIBLINGS HAVE CHILDREN? _____

MOTHER'S AGE AND HEALTH STATUS: _____

FATHER'S AGE AND HEALTH STATUS: _____

FAMILY HISTORY OF CANCER: _____

_____

_____

EXPLAIN FAMILY HISTORY OF GENETIC OR BIRTH DEFECTS: _____

_____

_____

PREVIOUS INFERTILITY TESTS / TREATMENTS

STATE CAUSE OF INFERTILITY & FERTILITY TREATMENTS (Dates / Type of Procedure / Results): _____

_____

_____

HYSTEROSCOPY (Date / Result): _____

HYSTEROSALPINGOGRAM (Date / Result): _____

CYCLE DAY 3 **HORMONES**: DATE _____ FSH _____ LH _____ E2 _____ TSH _____

PARTNER'S HISTORY

MALE NAME: _____

AGE: _____ ETHNICITY: _____

LIST ANY MEDICATIONS YOU HAVE ALLERGIES TO & YOUR REACTIONS: _____

_____

_____

PREGNANCIES INITIATED WITH CURRENT PARTNER: _____ PAST PARTNER? _____

PROVEN? ☐ Present Partner ☐ Previous Partner

MEDICAL HISTORY

PLEASE EXPLAIN ANY MEDICAL CONDITIONS YOU HAVE: _____

_____

_____

PLEASE LIST AND DATE ALL PAST SURGERIES AND/OR PROCEDURES (Major & Minor): _____

_____

_____

OCCUPATION: _____ STRESS LEVEL: _____

DO YOU USE A JACUZZI?

EXERCISE (Type / How Often): _____

DO YOU SMOKE? _____ IF YOU SMOKE, HOW MANY CIGARETTES PER DAY? _____

DO YOU DRINK? _____ IF YOU DRINK, HOW MANY ALCOHOLIC DRINKS PER DAY? _____

FAMILY HISTORY

HOW MANY BROTHERS DO YOU HAVE? _____

HOW MANY SISTERS DO YOU HAVE? _____

DO YOUR SIBLINGS HAVE CHILDREN? _____

MOTHER'S AGE AND HEALTH STATUS: _____

FATHER'S AGE AND HEALTH STATUS: _____

EXPLAIN FAMILY HISTORY OF GENETIC OR BIRTH DEFECTS: _____

_____

_____

SEMEN ANALYSIS DATE: _____

CONCENTRATION: _____ MOTILITY: _____

MORPHOLOGY: _____ PROGRESSION: _____ VOL: _____

INTAKE BY: _____

PHYSICAL EXAMINATION

HABITUS: _____

_____

_____

_____

_____

SKIN: WNL _____ OTHER _____

THYROID: WNL _____ OTHER _____

ABD: WNL _____ OTHER _____

PELVIC: BUS - WNL _____ OTHER _____

MANUAL: WNL _____ OTHER _____

ULTRASOUND: _____

_____

IMPRESSION: _____

_____

_____

_____

_____

PLAN: _____

_____

_____

_____

_____