



Welcome to Tennessee Reproductive Medicine. We appreciate the opportunity to serve you and promise to deliver exceptional care in a compassionate environment. Enclosed are several forms to facilitate your initial visit. Please complete and return these forms at least two (2) business days prior to your scheduled appointment. Completion and return of these forms allow us to update our records prior to your visit.

If you have additional records from a referring physician, please have these records forwarded as well.

On your first visit:

- Please arrive 10 minutes prior to your scheduled visit
- Please bring all insurance documentation
- Plan to be at the clinic for approximately 1 to 1 ½ hours
- Your physician will review your history and discuss evaluation options; treatment plans may be discussed or may be presented at subsequent visits.

For follow-up visits, please arrive 10 minutes prior to all scheduled visits.

Payment Policy

We accept various insurance plans. Please check with our schedulers when making your appointment regarding other specific companies. Please be aware that many insurance companies do not provide coverage for fertility investigations and/or treatments; therefore, we strongly encourage you to contact your insurance provider prior to your visit to understand your benefits.

Payment (Co-Pays, Deductibles, Co-Insurances, etc.) for each visit is expected in full at time of the visit.

For various lab services (i.e. semen analysis, sperm preps, and other lab tests), Tennessee Reproductive Laboratory, Inc. does not participate with any third party payers and is therefore a ***non-contracted laboratory***. All fees for such tests are due prior to or at time of testing. If a patient is interested in filing their claims directly, then please notify our staff for the appropriate forms. Tennessee Reproductive Laboratory does not file any claims with third party payers.

Cancellation Policy

We understand that scheduling needs change over time and would like to accommodate you whenever possible if an appointment must be changed. We kindly request at least a 24-hour notice to reschedule appointments. If no notice is given and an appointment is not kept, a \$50 cancellation charge will be applied.

For directions or more information, please call 423-876-2229 or visit www.trmbaby.com.

Patient ID: _____



TENNESSEE
REPRODUCTIVE
MEDICINE

Dr. Murray ____ Dr. Scotchie ____

DEMOGRAPHIC INFORMATION

Name: _____ Name you prefer to be called: _____

Marital Status: Married/ Single/Divorced/Separated/Widowed

Partner or spouse name (First, MI, Last) _____

Street address: _____

City: _____ State: _____ Zip Code: _____

Phones:	Order to be called	May we leave a message?
Home _____	1 – 2 – 3 Yes / No
Mobile _____	1– 2 – 3 Yes / No
Work _____	1 – 2 – 3 Yes / No

Email: _____

Date of birth (mm/dd/yyyy): _____ SSN: _____

Ethnicity/Race (please circle): Caucasian / African American / Hispanic / Asian / Mediterranean (Greek/Italian/other)

French Canadian / Eastern European / Other : / Other : _____

Local Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____ Pharmacy Fax: _____

Referral Information

How did you hear about us? (check all that apply:)

Referring Physician: _____
Referring Physician Phone: _____ Referring Physician Fax: _____

Internet, when searching for _____

Radio advertisement Billboard Print ad Women’s Expo/Taste of Home Show

Friend: _____ Other: _____

Patient ID: _____

Patient Name: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy Holder Name: _____

Policy Holder Sex: Male / Female

Is the contact information for the policy holder the same as the patient contact information? Yes / No
If No, please complete the information for the policy holder.

Policy Holder Street Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Mobile: _____ Work: _____

Please list the order of the preferred method of contact: 1) _____ 2) _____ 3) _____

May we leave messages at all of the numbers above? Yes _____ No _____

If no, list the number at which we may leave a message: _____

Email: _____ Relation to patient: _____

Date of birth (mm/dd/yyyy): _____ SSN: _____

Do you have secondary insurance? Yes / No

Patient ID: _____

Gynecologic History:

Age at 1st menstrual period _____ Number of days in cycle _____ Days of flow _____

Regular? Yes / No

Intermenstrual bleeding? Yes / No

Painful periods? Yes / No

(If yes, rate on a scale of 1-2-3-4-5-6-7-8-9-10)

Minimal $\xrightarrow{\hspace{2cm}}$ Severe

If yes, number of days per month: _____

Do you miss work on account of cramps? Y/N

Pain between periods? Yes / No

(If yes, rate on a scale of 1-2-3-4-5-6-7-8-9-10)

Minimal $\xrightarrow{\hspace{2cm}}$ Severe

If yes, number of days per month: _____

Painful Intercourse? Yes / No

(If yes, rate on a scale of 1-2-3-4-5-6-7-8-9-10)

Minimal $\xrightarrow{\hspace{2cm}}$ Severe

How often does pain with intercourse occur? Rare Occasionally With every attempt

Does pain prevent intercourse? Yes No

How often on average does patient have intercourse? _____

Date of last pap smear: _____

Any prior abnormal pap smears? Yes / No

How was it treated? _____

Date of last abnormal pap? _____

Date of last breast exam: _____ Have you ever had any breast masses? Yes / No

Date of last mammogram? _____ Findings: _____

Have you ever used contraception? Yes / No

If yes, please list method and dates of use: _____

Have you ever had a gynecologic infection other than yeast or bacterial vaginosis? Yes/ No

If yes, please list infection, date and treatment: _____

Have you ever had gynecologic surgery? Yes / No

If yes, please list each surgery below

Procedure	Date	Findings
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Fertility History:

Have you ever seen another fertility specialist? Yes / No

If “yes”, physician name and phone number: _____

Please list prior infertility diagnoses: _____

Have you or your partner undergone any of the following evaluations?

Test	Date	Results
Ovulation Predictor Kit	_____	_____
Prolactin	_____	_____
Thyroid	_____	_____
Day 3 FSH, Estradiol	_____	_____
Progesterone	_____	_____
Hysterosalpingogram	_____	_____
Semen Analysis	_____	_____
Other	_____	_____

Have you undergone any of the following treatments?

Treatment	Dose	Number of cycles	Dates
Clomid/Timed Intercourse	_____	_____	_____
Clomid/Insemination	_____	_____	_____
Injectables/Timed intercourse	_____	_____	_____
Injectables/Insemination	_____	_____	_____
IVF	_____	_____	_____
Other	_____	_____	_____

Have you had any of the following tests done for Recurrent Pregnancy Loss?

- | | |
|---|--|
| <input type="checkbox"/> Female karyotype | <input type="checkbox"/> Male karyotype |
| <input type="checkbox"/> HSG/Hysteroscopy | <input type="checkbox"/> Ureaplasma or mycoplasma culture or treatment |
| <input type="checkbox"/> Anticardiolipin antibodies | <input type="checkbox"/> Lupus Anticoagulant |
| <input type="checkbox"/> Antiphospholipid antibodies | <input type="checkbox"/> MTHFR Mutation |
| <input type="checkbox"/> Factor V Leiden | <input type="checkbox"/> Prothrombin Mutation |
| <input type="checkbox"/> Protein C Deficiency | <input type="checkbox"/> Protein S Deficiency |
| <input type="checkbox"/> Antithrombin III Deficiency | <input type="checkbox"/> Activated Protein C Resistance |
| <input type="checkbox"/> Other or Unknown Names _____ | |

Medical & Other Surgical History:

Height: _____ Weight: _____

Please list any medical conditions:

1. _____
2. _____
3. _____
4. _____

Have you had chicken pox? Yes ___ No ___

Please list all prior surgeries (other than gynecological procedures listed previously):

Procedure & Date	Physician	Findings
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Allergies (list all reactions and offending drug or agent):

1. _____
2. _____
3. _____
4. _____

Medications (Please include dosages):

1. _____
2. _____
3. _____
4. _____

Environmental & Family History:

Do you smoke? Yes / No If yes, number of cigarettes per day: _____ Years _____

Did you smoke in the past? Yes/No If yes, please list start date _____ and stop date (or year)_____.

How many alcoholic beverages do you consume per week? _____

Do you use illicit drugs? Yes / No. If yes, list drug and frequency: _____

Have you ever been in an abusive (physically, mentally, or emotionally) relationship? Yes / No

Occupation: _____

Is there a family history of any of the following conditions?

Condition	Affected Person	Condition	Affected Person
<input type="checkbox"/> Down Syndrome	_____	<input type="checkbox"/> Spina bifida (open spine)	_____
<input type="checkbox"/> Heart defect	_____	<input type="checkbox"/> Mental retardation	_____
<input type="checkbox"/> Premature menopause	_____	<input type="checkbox"/> Breast Cancer	_____
<input type="checkbox"/> Ovarian Cancer	_____	<input type="checkbox"/> Other birth defects	_____
<input type="checkbox"/> Autism	_____	<input type="checkbox"/> Learning disability/ADHD	_____
<input type="checkbox"/> Sickle Cell Anemia	_____	<input type="checkbox"/> Cystic Fibrosis	_____
<input type="checkbox"/> Other inherited disorder	_____		

Ethnicity/Race (please circle): Caucasian / African American / Hispanic / Asian / Mediterranean (Greek/Italian/other)/French Canadian / Eastern European / Other : / Other : _____

Do you have any of the following ancestry in your family?

- Ashkenazi Jewish French Canadian

Have you or your partner been screened for the Cystic Fibrosis carrier mutation? Yes / No
If yes, results: _____

Review of systems:

Please circle any of the following symptoms you have experienced within the last 3 months

- General:** Fevers, fatigue, weight changes, weakness, eating disorders
- Skin:** Rash, ulcers, change in mole size, acne, hair growth
- Eyes:** Change in vision, eye pain, blurry vision
- Breast:** Pain, discharge, lump, skin changes
- Respiratory:** Cough, shortness of breath, wheezing, coughing blood, chest pain, asthma
- Cardiovascular:** Irregular heart beat, chest pain, palpitations, difficulty breathing when walking, difficulty breathing when laying down, leg swelling
- GI:** Abdominal pain, nausea, vomiting, diarrhea, constipation, blood in stools, heartburn
- GU:** Painful urination, blood in urine, incontinence
- Musculoskeletal:** Painful joints or muscles, back pain, hip pain
- ENT:** Sore throat, difficulty hearing, sinus problems
- Nervous system:** Headaches, dizziness, fainting, seizures, difficulty walking
- Psychology:** Depression, anxiety, bipolar disorder, crying
- Endocrine:** Unwanted hair growth (on face, abdomen, chest or back), acne, hair loss, loss of breast size, excessive sweating, hot flashes, vaginal dryness, constant thirst, frequent urination, skin tags, darkening of skin around neck or in folds of skin

Medical History (Partner/Husband History, if applicable):

Partner or spouse name (First, MI, Last) _____ Age _____

Have you previously been married? Yes ___ No ___

Have you previously fathered any pregnancies? Yes ___ No ___

If yes, were the pregnancies with current partner/wife _____ former partner/wife _____

If Yes, please list the following:

Date of pregnancy: _____ Type of pregnancy (live birth, miscarriage, ectopic, elective abortion)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Male risk factors for infertility: If any responses are Yes, please explain in space.

Prior abnormal semen analysis? Y / N _____

Prior testicular torsion? Y / N _____

Prior testicular/pelvic trauma? Y / N _____

Prior Head trauma? Y / N _____

Low libido?(sex drive) Y / N _____

Varicocele? Y / N _____

Prior Vasectomy reversal? Y / N _____

History of Mumps after puberty? Y / N _____

Frequent hot tub or sauna use? Y / N _____

Any past or current anabolic steroid or creatine use? Y / N _____

Prior radiation or cancer treatment? Y / N _____

Recent fever? Y / N _____

History of tobacco abuse? Y / N _____

Major medical illness? Y / N _____

Please list all prior surgeries:

Procedure & Date	Physician	Findings
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Have you had any prior sexually transmitted infections? Yes ___ No ___

If "Yes", list infection: _____ Date _____

Was treatment received? Yes ___ No ___

Medical History (Partner/Husband History, if applicable – Continued):

Allergies (list all reactions and offending drug or agent):

1. _____
2. _____
3. _____
4. _____

Medications (Please include dosages):

1. _____
2. _____
3. _____
4. _____

How many alcoholic beverages do you have per week? _____

Do you smoke? Yes / No If yes, number of cigarettes/day? _____ Years _____

Do you use any illicit drugs? Yes / No

Occupation: _____

Is there a family history of any of the following conditions?

Condition	Affected Person	Condition	Affected Person
<input type="checkbox"/> Down Syndrome	_____	<input type="checkbox"/> Spina bifida (open spine)	_____
<input type="checkbox"/> Heart defect	_____	<input type="checkbox"/> Mental retardation	_____
<input type="checkbox"/> Autism	_____	<input type="checkbox"/> Other birth defects	_____
<input type="checkbox"/> Cystic Fibrosis	_____	<input type="checkbox"/> Learning disability/ADHD	_____
<input type="checkbox"/> Other inherited disorder	_____	<input type="checkbox"/> Sickle Cell Anemia	_____

Ethnicity/Race (please circle): Caucasian / African American / Hispanic / Asian / Mediterranean (Greek/Italian/other)/French Canadian / Eastern European / Other : / Other : _____

Do you have any of the following ancestry in your family?

- Ashkenazi Jewish French Canadian

Patient ID: _____

MALE DEMOGRAPHIC INFORMATION

Name: _____ Name you prefer to be called: _____

Marital Status: Married/ Single/Divorced/Separated/Widowed

Partner or spouse name (First, MI, Last) _____

Street address: _____

City: _____ State: _____ Zip Code: _____

Phones:	Order to be called	May we leave a message?
Home _____	1 – 2 – 3 Yes / No
Mobile _____	1– 2 – 3 Yes / No
Work _____	1 – 2 – 3 Yes / No

Email: _____

Date of birth (mm/dd/yyyy): _____ SSN: _____

Ethnicity/Race (please circle): Caucasian / African American / Hispanic / Asian / Mediterranean (Greek/Italian/other)

French Canadian / Eastern European / Other : / Other : _____

Local Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____ Pharmacy Fax: _____

Referral Information

How did you hear about us? (check all that apply:)

Referring Physician: _____
Referring Physician Phone: _____ Referring Physician Fax: _____

Internet, when searching for _____

Radio advertisement Billboard Print ad Women's Expo/Taste of Home Show

Friend: _____ Other: _____

Patient ID: _____

Patient Name: _____

MALE INSURANCE INFORMATION

Insurance Company: _____ Policy Holder Name: _____

Policy Holder Sex: Male / Female

Is the contact information for the policy holder the same as the patient contact information? Yes / No
If No, please complete the information for the policy holder.

Policy Holder Street Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Mobile: _____ Work: _____

Please list the order of the preferred method of contact: 1) _____ 2) _____ 3) _____

May we leave messages at all of the numbers above? Yes _____ No _____

If no, list the number at which we may leave a message: _____

Email: _____ Relation to patient: _____

Date of birth (mm/dd/yyyy): _____ SSN: _____

Do you have secondary insurance? Yes / No

Patient ID: _____

CONSENT FOR EMAIL COMMUNICATION

I agree that I have been offered various forms of communication with Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) including telephone, fax, mail and email. I request that email may be used to communicate health information including future lab results. I understand that email accounts are not always secure and may not be able to protect the privacy of my health information. While TRM and TRL may be able to confirm the security of TRM's and TRL's email accounts, we cannot confirm the security of personal patient email accounts. Therefore, by signing this agreement, I relinquish TRM and TRL from any and all liabilities related to personal health information conveyed in email format if this is my chosen mode of contact for receiving lab results.

Please note that only short correspondence of evaluation results will be communicated via email. Physician consults cannot be conducted via email.

Signature: _____

Printed Name: _____

Date: _____

CONSENTS FOR FEMALE PATIENT

Printed Patient Name: _____

CONSENT FOR MEDICAL TREATMENT

I authorize Drs. Ringland Murray and Jessica Scotchie and their staff of Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) to conduct evaluations and render treatment for conditions related to fertility, reproductive endocrinology, gynecology and any associated disorders which may affect one of the prior conditions.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, TREATMENT INSTRUCTIONS AND PRESCRIPTIONS

I authorize Drs. Ringland Murray and Jessica Scotchie and their staff of Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) to release information pertaining to my care to the phone numbers listed in my new patient information packet, pharmacy, referring physician, reference laboratories and insurance companies. I agree to update Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) of any changes in my contact information, insurance company and pharmacy. I understand that I have the right to withdraw this consent for the release of information at any time. Such withdrawal must be in writing. No information can be released after consent has been withdrawn.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I have received a copy of Tennessee Reproductive Medicine, PLLC's Notice of Privacy Practices as required by HIPAA Privacy Regulations developed October 2002.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NEW PATIENT PACKET AND FINANCIAL RESPONSIBILITY

I am aware that every effort has been made to verify my insurance coverage for services provided by Tennessee Reproductive Medicine (TRM). I understand that services rendered may not be covered by my health insurance or other health benefit program and I will be financially responsible for those services performed by Tennessee Reproductive Medicine (TRM) not covered by my health insurance. I also understand that Tennessee Reproductive Laboratories (TRL), which performs semen analyses, laboratory evaluation during treatment cycles and all laboratory management during assisted reproductive technology treatments, does not participate with any third party payers and is therefore a non-contracted laboratory. I agree to be financially responsible for any and all services rendered by Tennessee Reproductive Laboratories (TRL) prior to initiating treatment. I understand that payment for all services is expected in full at each visit. I acknowledge receipt and understanding of the New Patient Packet and all information included therein, and I accept responsibility for the terms and conditions related to financial responsibility.

Signature: _____ Date: _____

CONSENTS FOR HUSBAND/MALE PARTNER

Printed Female Patient Name: _____

CONSENT FOR MEDICAL TREATMENT

I authorize Drs. Ringland Murray and Jessica Scotchie and their staff of Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) to conduct evaluations and render treatment for conditions related to fertility, reproductive endocrinology, gynecology and any associated disorders which may affect one of the prior conditions.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, TREATMENT INSTRUCTIONS AND PRESCRIPTIONS

I authorize Drs. Ringland Murray and Jessica Scotchie and their staff of Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) to release information pertaining to my care to the phone numbers listed in my new patient information packet, pharmacy, referring physician, reference laboratories and insurance companies. I agree to update Tennessee Reproductive Medicine (TRM) and Tennessee Reproductive Laboratories (TRL) of any changes in my contact information, insurance company and pharmacy. I understand that I have the right to withdraw this consent for the release of information at any time. Such withdrawal must be in writing. No information can be released after consent has been withdrawn.

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Signature: _____ Date: _____