Welcome to the UT Medicine Fertility Center. The UT Medicine Fertility Center is a part of the UT Medicine Women’s Health Center, the clinical center for the Department of Obstetrics and Gynecology of The University of Texas Health Science Center - San Antonio. At UT Medicine Fertility Center, we offer a comprehensive program of fertility-related services encompassing the latest advances in fertility research, state-of-the-art technology, and sophisticated laboratory procedure. In addition, we offer an extensive education program for our patients, as well as the entire community, in order to foster a better understanding of disorders of fertility and reproductive endocrinology.

We offer our patients several options for counseling should they so desire. We can provide information regarding community support groups. We also work closely with a psychologist and a marriage and family therapist. Referrals can be arranged at your request.

The UT Medicine Fertility Center is staffed exclusively by reproductive endocrinologists, all of whom have full-time faculty appointments at The University of Texas Health Science Center at San Antonio. Our physicians include:

Robert S. Schenken, M.D.
Robert G. Brzyski, M.D., Ph.D.
Randal D. Robinson, M.D.

The UT Medicine Fertility Center is open from 7:30 am to 4:30 pm. Monday through Friday. In addition, we have limited morning office hours on Saturdays and most holidays. It is necessary to schedule all appointments in advance. All of our physicians, as part of their academic appointments at the medical school, are actively involved in research and teaching. Therefore, while your individual physician will always coordinate your care and will make all decisions concerning your treatment, you may see another physician for minor office visits. Surgical procedures will always be performed by your physician.

The center is located at the Medical Arts and Research Center, 8300 Floyd Curl Drive, San Antonio, TX 78229. Parking is available on the ground floor of the building. We can be contacted at (210) 450-9500.
UT Medicine Fertility Center
Fertility Services

Medical Arts and Research Center
8300 Floyd Curl Drive, 5th Floor
San Antonio, TX 78229
210-450-9500

Date:___________ Date & Time of Appointment:______________

Dear ____________________________:

Enclosed is a welcome letter, a new patient information packet and an infertility history form.

Please fill out the new patient information packet, and the infertility history form as completely as possible and return it to us by mail or email as soon as possible.

The day of your initial visit you will need to bring your medical records that pertain to your problem, and your insurance card for future billing of insurance if so desired.

Your assistance with this paperwork will help us to provide you with the quickest possible office visit.

Thank you for your attention to this matter. If you have any questions, please feel free to call.

We look forward to working with you.

LOCATION OF UT MEDICINE FERTILITY CENTER AT THE MARC
PLEASE FILL IN AS COMPLETELY AS POSSIBLE

UT Medicine Fertility Center
Infertility History Form

Date of Visit: _______________________
Your Name:_________________________ Age:_________________________ Birthdate:__________
Address:____________________________
Home Telephone:______________________ Physician who referred you:____________________
Your Occupation:______________________
Your Employer:______________________ Telephone (work)____________________________
Spouse’s Name (if applicable):______________________________________________
Spouse’s Occupation:_______________Spouse’s Telephone (work)______________________
Reason for your clinic visit:______________________________________________

Describe as thoroughly as possible the background of your present problem. Include all
symptoms, how long you have experienced them and indicate whether they have become
worse, lessened or stayed the same in severity over time.

__________________________________________________________________________
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MENSTRUAL HISTORY:
At what age did you begin to menstruate?
What were the dates of your last two menstrual periods?
Have you ever gone more than 3 months without having a period? Yes No
If so, how long? (mos./yrs.)________________ Approximate date(s) when this occurred:
________________________________________
Are you normally regular irregular?
If irregular, please describe ________________________
What is the average length of your menstrual cycle? (Interval from 1st day of bleeding until day before bleeding of next cycle):
Has this changed since you started having periods? Yes No Explain: ________________
How many days do you bleed? ________________________
Is your flow light medium heavy?
Does this vary?__________________________
If so, explain: ____________________________
Do you have pain during periods? Yes No (Describe):__________________________
Any pain between periods? Yes No (Describe):__________________________
Do you bleed between periods? Yes No Describe frequency and amount of blood loss:
Frequency of intercourse:
_______times per week _______times per month ___________ N/A
Do you have any problems with intercourse? Yes No N/A
Any changes in sex drive? Yes No N/A
Do you bleed during or after intercourse? Yes No N/A
Any pain during or after intercourse? Yes No N/A
Do you have any vaginal discharge? Yes No N/A
If yes, describe your discharge:________________________________________
________________________________________
Have you had regular gynecologic exams? Yes No
Date of last exam _______________________________________________________
Date & result of last Pap smear_____________________________________________
Have you had regular breast examinations? Yes No
Date of last exam _______________________________________________________
Date & findings of last abnormal exam_____________________________________
Date & findings of last mammogram_______________________________________
Have you ever had a milky discharge from one or both breasts? Yes No
If so, when_____________________________________________________________
Have you had a history of: (If yes, please give date)
Chlamydia_____________________________________________________________
Gonorrhea______________________________________________________________
Pelvic (tubal) infection____________________________________________________
### OBSTETRICAL HISTORY

___ Not Applicable
(continue on to next section)

<table>
<thead>
<tr>
<th>Number</th>
<th>Date(s)</th>
<th>Months to Conceive?</th>
<th>Sex/Wt.</th>
<th>Vag./C-section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Term Deliveries (37 weeks or more)</td>
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<td></td>
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<tr>
<td>Premature Deliveries (less than 37 weeks)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Number</th>
<th>Date(s)</th>
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</thead>
<tbody>
<tr>
<td>Miscarriages</td>
<td></td>
</tr>
<tr>
<td>Abortions</td>
<td></td>
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<tr>
<td>Ectopic Pregnancies</td>
<td></td>
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<tr>
<td>Stillbirths</td>
<td></td>
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<tr>
<td>Newborn Deaths* <em>(within 1 month of birth)</em></td>
<td></td>
</tr>
</tbody>
</table>

**Were there any complications during or after your deliveries?**

Yes  No

If yes, state which delivery and describe the complication(s):

---

**Were any of your children born with birth defects?**

Yes  No

If yes, state which delivery and describe the birth defect:

---

Dates of pregnancies with present husband/partner:

Number of living children from this marriage/relationship:

Did you have any pregnancies/children from a previous spouse/partner?  Yes  No

If yes, list the dates of pregnancies:

And living children:

If applicable, dates of pregnancies through artificial insemination (**donor** sperm only):

_________________________And living children:_________________________
**CONTRACEPTION:**

Not Applicable
(continue on to next section)

Please check any of the following methods of contraception you are currently using and/or have used in the past. Fill in the dates of usage.

<table>
<thead>
<tr>
<th>Method</th>
<th>Dates of Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Control Pills</td>
<td>Type:_________</td>
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<tr>
<td>IUD</td>
<td>Type:_________</td>
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<tr>
<td>Diaphragm</td>
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<tr>
<td>Condom</td>
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<tr>
<td>Jellies/Foam</td>
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<tr>
<td>Withdrawal</td>
<td></td>
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<tr>
<td>Sterilization</td>
<td>Male  Female</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
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</tbody>
</table>

**GENERAL MEDICAL HISTORY:**

Do you have any allergies? (Specify):______________________________

List current medications: State the name of medication, indication for its use, and how long you’ve taken it. Include both prescription and over-the-counter medication.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Starting</th>
<th>Through</th>
<th>Amount</th>
<th>Indications</th>
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</table>

List all serious medical illnesses with date(s). If hospitalized, where?

____________________________________________________________________

____________________________________________________________________

List all surgical procedures you have had, the approximate date(s), duration of your hospitalization(s) and name of hospital(s):

____________________________________________________________________

____________________________________________________________________

Your General Health: Excellent Good Fair Poor

Childhood Illnesses: Routine (chicken pox, measles, mumps, etc.)

Unusual (Describe):______________________________
Have you ever had a blood transfusion? Yes No
Approximate date:_________________________________________________________

Do you drink alcohol? Daily Weekly Monthly Never
Do you smoke cigarettes? Yes No
Number of packs per day:__________________________________________________
If you smoked in the past and have quit, give the approximate dates of smoking:
_____________________________________________________________________

Drug usage in past year:
Marijuana Cocaine Depressants Stimulants
State the substances and amount of use:_____________________________________

Have you had any difficulty or recent change in your habits of sleep, diet or exercise?
Yes No If so, describe:_____________________________________________________

________________________________________________

**FAMILY HISTORY**

Check any of the following disorders which have occurred in your family. Next to each item state
which family member (mother, maternal grandmother, etc.) had the problem. *This section does not
refer to any problems that you yourself have had.*

- Cancer (specify) ____________________________  Baby with birth defects/retardation
- Diabetes  Seizures  Chromosome (genetic)
- Thyroid disorders  Obesity  Other: (specify) __________
- Heart disease  Psychiatric disorders
- Hypertension  Infertility
- Tuberculosis  Multiple Miscarriages

**REVIEW OF SYSTEMS**

Check any of the following disorders you currently have or have a history of.

**Central Nervous System**
- Seizures
- Migraine headaches
- Other

**Physician’s Notes**

**EENT**
- Eye disorders
- Double or blurry vision
- Problem with sense of smell
- Other
Cardiovascular

Chest pain
Palpitations
Diagnosed with Rheumatic fever
Heart valve disease
High blood pressure
Mitral valve prolapse
Given prophylactic antibiotics
Other

Respiratory

Shortness of breath
Asthma (Date of Last Attack)
Bronchitis
Pneumonia
Cough producing blood
Tuberculosis
Other

Gastrointestinal

Nausea/Vomiting
Blood in stool
Ulcers
Hepatitis
Constipation
Spastic Colon
Other

Genito-urinary

Bladder infections (cystitis)
Kidney infection
Vaginal infections
Frequent urination
Other

Musculo-Skeletal

Unusual muscle weakness
Decreased energy/stamina
Rheumatoid arthritis
Lupus erythematosus
Other

Hematologic

Blood clotting disorder
Sickle cell anemia or trait
Thrombophlebitis
Other
Endocrine Diabetes

Thyroid disease
Excessive growth of hair on various parts of the body
Hair loss
Unexplained rash
Rapid weight gain
Rapid weight loss
Excessive hunger/thirst
Other

Skin
Unexplained Rash
Acne
Skin Cancer
Injuries
Dermatitis
Other

**HUSBAND/PARTNER HISTORY**

Birth date of husband/partner __________________________ Present Age __________________________

Duration of present marriage/relationship: __________________________________________

Has husband/partner initiated a pregnancy in a previous relationship?  Yes  No
If yes, please give dates and outcome of pregnancy. _______________________________________

Has husband/partner had a previous relationship where pregnancy did not occur even though no contraception was used?  Yes  No
If yes, how long a period was involved? ________________________________________________

Any difficulty achieving or maintaining an erection?  Yes  No

Any difficulty with ejaculation (e.g., retrograde, premature)?  Yes  No

Any history of possible reproductive tract problem, (including dates) e.g., Prostatitis Epididymitis Orchitis Testicular tumor Injury to testes

Any history of transmissible disease?  gonorrhea  chlamydia
Non-specific urethritis  syphilis

Any history of reproductive tract surgery?  Yes  No
If yes, please give procedure and date ________________________________________________
MEDICAL HISTORY OF HUSBAND/PARTNER

Does husband/partner have any allergies? (specify): ____________________________

List current medications: State the name of medication, indication for its use, and how long medication has been taken. Include both prescription and over-the-counter mediation.

<table>
<thead>
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</tbody>
</table>

List all surgical procedures, approximate date, and hospital which husband/partner has undergone. ____________________________

______________________________________________________________

List all significant medical illnesses requiring treatment. Include dates and name of physician/hospital which husband/partner has experienced.

______________________________________________________________

______________________________________________________________

General Health: Excellent Good Fair Poor
Childhood Illnesses: Routine (chicken pox, measles, mumps, etc.)
Unusual (Describe): ____________________________

Has husband/partner ever been in a serious accident? (describe) ____________________________

Has husband/partner ever had a blood transfusion? Yes No Approximate date: ____________________________

Does husband/partner drink alcohol? Daily Weekly Monthly Never

Does husband/partner smoke cigarettes? Yes No

Drug usage in past year: Marijuana Cocaine Depressants Stimulants
Any difficulty or recent change in your habits of sleep, diet, or exercise?__________________________________________

Any recent illnesses or change in health?  Yes  No
If yes, please describe__________________________________________

Any recent significant weight changes?__________________________________________
Present Weight__________Height______________________________

Has husband/partner been exposed to high temperatures (work, hot tubs, etc.)________
Radiation    Chemicals    Toxic substances

PAST INFERTILITY EVALUATION

Check all that apply:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date(s)</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband/partner semen analysis</td>
<td></td>
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<tr>
<td>Temperature charts</td>
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<tr>
<td>Postcoital tests</td>
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<tr>
<td>Endometrial biopsy</td>
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<tr>
<td>X-ray of tubes</td>
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<tr>
<td>Diagnostic laparoscopy</td>
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<tr>
<td>Hysteroscopy</td>
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<tr>
<td>Hormonal tests (which?)</td>
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<tr>
<td>Chromosomal studies (which)</td>
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</tbody>
</table>

Medications taken:__________________________________________

Please feel free to use the following section for any additional information you feel may be helpful in your fertility evaluation:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Initials  I authorize UT Medicine San Antonio to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, continuity of care and medical treatment.

CONSENT FOR TREATMENT

Initials  As a consulting adult and/or legal guardian, I agree to permit the physicians and staff of UT Medicine San Antonio to provide medical care to myself, my child or the patient I represent, as applicable. By signing below, I agree to permit the physician and staff at UT Medicine San Antonio to perform necessary or appropriate medical care including physical examination, diagnosis, and treatment.

ASSIGNMENT OF BENEFITS

Initials  I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans, to UT Medicine San Antonio. I understand that I am responsible to follow up with insurance plan due to any discrepancy in coverage. I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize UT Medicine San Antonio to release all information necessary to secure payment.

I have read the Authorization Release of Medical Records, Consent for Treatment and Assignment of Benefits.

Patient Name: ___________________________ Date: ____________

PRINT NAME

Signature of Patient
Or Legal Guardian: ___________________________ Date: ____________

Relationship to Patient: ____________________________

Witness: ___________________________ Date: ____________
# New Patient Information

## Patient Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Suffix (Jr, Sr, etc.)</th>
<th>Title (Mr., Mrs., Ms, Dr)</th>
<th>Sex</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Alias or Nickname (Last, First, Middle)</th>
<th>Marital Status</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Permanent Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>County</th>
<th>Country</th>
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</thead>
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<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Other</th>
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</table>

Which phone number would you like to use as your primary contact? ________________

<table>
<thead>
<tr>
<th>Temporary Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>County</th>
<th>Country</th>
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</table>

For Temporary Address, please provide: Start Date: ________________ Stop Date: ________________

## Referring Physician and Primary Care Provider (PCP) Information

What provider referred you to our clinic today? 

<table>
<thead>
<tr>
<th>Name (Last, first)</th>
<th>Address</th>
<th>Phone#</th>
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</table>

Name of PCP (Last, First) 

<table>
<thead>
<tr>
<th>Address</th>
<th>Office Phone #</th>
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</table>

## Employment Information

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Employer Phone Number</th>
<th>Employer Address (Street, City, Zip Code)</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Occupation</th>
<th>Employment Status (part-time, full-time)</th>
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## Emergency Contact Information

1. Name (Last, First, Middle) Relationship to Patient Telephone (Home, Work, Cell)

2. Name (Last, First, Middle) Relationship to Patient Telephone (Home, Work, Cell)

## Guarantor

(If self, please skip to insurance section)

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Sex</th>
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<tbody>
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<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Home Phone</th>
<th>Work Phone</th>
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<th>Employer Phone Number</th>
<th>Employer Address (Street, City, Zip Code)</th>
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</table>
**PRIMARY INSURANCE**

Name of Insurance

**SUBSCRIBER INFORMATION (if self, please skip to Secondary Insurance)**

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Last Name</th>
<th>First Name</th>
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**SECONDARY INSURANCE**

Name of Insurance

**SUBSCRIBER INFORMATION (if self, please skip to Secondary Insurance)**

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Sex</th>
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<thead>
<tr>
<th>Social Security Number</th>
<th>Date of Birth</th>
<th>Home Phone</th>
<th>Work Phone</th>
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<tr>
<th>Permanent Address</th>
<th>City</th>
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<tr>
<th>Name of Employer</th>
<th>Employer Phone Number</th>
<th>Employer Address (Street, City, Zip Code)</th>
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<tr>
<th>Occupation</th>
<th>Employment Status (Part-time, Full-time)</th>
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**IF THIRD INSURANCE, PLEASE LIST**

Name of Insurance

Please be ready to provide:
1. Your insurance card(s)
2. Your driver’s license or ID
3. Visit co-payment
Notice of Privacy Practices

Effective Date: April 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY AND SIGN THE ACKNOWLEDGEMENT FORM

1. Purpose: The University of Texas Health Science Center at San Antonio (UT Health Science Center) and its faculty, students, residents, employees, non-employees, and its affiliates (UT Medicine Physicians Group and its clinics) follow the privacy practices described in this Notice. The UT Health Science Center maintains your health information in records that are kept in a confidential manner, as required by law. The UT Health Science Center must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

2. What Are Treatment, Payment, and Health Care Operations? Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with the pharmacist to discuss medications, or with radiologists or other consultants to make a diagnosis. UT Health Science Center may use your health information as required by your insurer or HMO to obtain payment for your treatment. UT Health Science Center may use and disclose your health information to improve the quality of care and for education and training purposes of UT Health Science Center students, residents, and faculty.

3. How Will the UT Health Science Center Use and Disclose My Health Information? Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:

   Note: You will have the opportunity to refuse some of these communications about your health information, indicated by (*).

   • UT Health Science Center directories, which may include your name, general condition, and your location in the UT Health Science Center. *
   • Religious affiliation to a hospital chaplain or member of the clergy. *
   • Family members or close friends involved in your care or payment for treatment. *
   • Disaster relief agency if you are involved in a disaster relief effort. *
   • To inform you of treatment alternatives or benefits or services related to your health. *
   • Fundraising activities by the UT Health Science Center. Such information will be limited to your name, address, phone number, age, gender, insurance status, and the dates you received services at the UT Health Science Center.*
   • Appointment reminders.
   • Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence.
   • Health oversight activities, such as audits, inspections, investigations, and licensure.
   • Law enforcement.
   • Coroners, medical examiners, and funeral directors.
   • Organ and tissue donation.
   • Certain research projects.
   • To prevent a serious threat to health or safety.
   • To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
   • National security and intelligence activities to authorized persons to conduct special investigations.
   • Workers’ Compensation. Your medical information regarding benefits for work-related injuries and illnesses may be released as appropriate.
• Alcohol and drug abuse information has special privacy protections. The UT Health Science Center will not
disclose any information identifying an individual as being a patient or provide any health information
relating to the patient's substance abuse treatment unless the patient consents in writing; to carry out
treatment, payment, and operations; or as required by law.
• To carry out health care treatment, payment, and operations functions through business associates, such
as to install a new computer system.

4. **Your Authorization Is Required for Other Disclosures.** Except as described above, we will not use or
disclose your medical information, unless you allow the UT Health Science Center in writing to do so. For
example, we will not use your photographs for presentations outside the UT Health Science Center without
your written permission. You may withdraw or revoke your permission, which will be effective only after the
date of your written withdrawal.

5. **You Have Rights Regarding Your Health Information.** You have the following rights regarding your medical
information, if requested on the form(s) provided by the UT Health Science Center:
• **Right to request restriction.** You may request limitations on your health information that we use or
disclose for health care treatment, payment, or operations, although we are not required to comply with
your request. For example, you may ask us not to disclose that you have had a particular procedure. We
will release the information if necessary for emergency treatment.
• **Right to confidential communications.** You may request communications of your health information in a
certain way or at a certain location, but you must tell us how or where you wish to be contacted.
• **Right to inspect and copy.** You have the right to review and obtain a copy of your medical or health
record. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your
request may be denied; you may request review of the denial by another licensed health care professional
chosen by the UT Health Science Center. The UT Health Science Center will comply with the outcome of
the review.
• **Right to request amendment.** If you believe that the health information we have about you is incorrect or
incomplete, you may request an amendment on the form provided by the UT Health Science Center. The
UT Health Science Center is not required to accept the amendment.
• **Right to accounting of disclosures.** You may request a list of the disclosures of your health information
that have been made to persons or entities for disclosures unrelated to health care treatment, payment, or
operations within the past six (6) years, but not prior to April 14, 2003. After the first request, there may be
a charge.
• **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have
been provided with an electronic copy. You may obtain an electronic copy of this Notice at our web site,
http://www.uthscsa.edu/hipaa/patientrights.html. A more detailed Notice is also available at this website if
you would like more information about these practices.

6. **Requirements Regarding This Notice.** The UT Health Science Center is required by law to provide you with
this Notice. We will comply with this Notice for as long as it is in effect. The UT Health Science Center may
change this Notice, and these changes will be effective for health information we have about you, as well as
any information we receive in the future. Each time you register at the UT Health Science Center for health
services, you may receive a copy of the Notice in effect at the time.

7. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the UT Health
Science Center’s Privacy Officer (210/567-5212) or with the Secretary of the United States Department of
Health and Human Services. We will not penalize or retaliate against you in any way for making a complaint to
The University of Texas Health Science Center at San Antonio or to the Department of Health and Human
Services.

**Contact UT Medicine’s Privacy Officer at (210) 257-1627 if:**
• You have any questions about this Notice;
• You wish to request restrictions on uses and disclosures for health care treatment, payment, or
operations; or
• You wish to obtain a form to exercise your individual rights described in paragraph 5.

**PLEASE BRING THE ACKNOWLEDGEMENT FORM WITH YOU TO YOUR CLINIC VISIT.**
Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have received a copy of UT Medicine San Antonio/UTHSCSA Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in UT Medicine San Antonio/UTHSCSA Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the UT Medicine San Antonio/UTHSCSA Patient Privacy Officer at (210) 257-1627.

Authorization:

Do you authorize your immediate family member(s) to have access to your medical records/information?

† Yes
† No

If yes, please list the name(s) of the AUTHORIZED family member(s):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

PRINT Patient Name

If Patient Representative, PRINT name and relationship to Patient

Patient Signature

Patient Representative Signature

Date Notice Received

Witness Signature  Date
Disclosure of your Social Security Number (SSN) is required of you in order for UT Medicine San Antonio to bill and collect for patient services under Medicare or Medicaid. Federal law mandates a social security number is required to obtain benefits under Medicare and Medicaid (42 USC, Section 1320b-7(1)). For commercial insurance, there is no statute or authority that requires that you disclose your SSN. Failure to provide your SSN, however, may cause the insurance company to deny payment for lack of SSN. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information UT Medicine collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have UT Medicine correct information about you that is held by UT Medicine and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that UT Medicine at San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.

You may send any requests to UT Medicine HIPAA Compliance
By mail to: 6126 Wurzbach Road San Antonio TX 78238
By e-mail to: UPGPrivacy@UTHSCSA.edu
By fax to: (210) 257-1436
In person at: 6126 Wurzbach Road San Antonio TX 78238
CONSENT FOR DISCLOSURE OF SOCIAL SECURITY NUMBER FOR PATIENT BILLING AND COLLECTIONS

I hereby consent to the disclosure of my Social Security Number by UT Medicine San Antonio for the stated purpose listed on Notice.

Patient Name (please print): __________________________________________________________

Patient Signature: _________________________________________________________________

Date Consent Signed: _______________________________________________________________

Acknowledgement of Receipt of Notice of Request for Social Security Number for Patient Billing and Collections

Your name and signature on this sheet indicate that you have received a copy of UT Medicine San Antonio’s Notice of Request for Social Security Number on the date indicated. If you have any questions regarding the information in the Notice of Request for Social Security Number for Patient Billing, please do not hesitate to contact the Clinic Manager or the UTM Administrator indicated on your Notice.

Patient Name (please print): __________________________________________________________

Patient Signature: _________________________________________________________________

Date Consent Signed: _______________________________________________________________

PLEASE SUBMIT THIS PAGE TO THE FRONT DESK