The Fertility Center

William Dodds MD, Valerie Shavell MD,
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FAX TRANSMITTAL MEMO

Please fax, mail or email (medrec@mrivf.com) new patient paperwork to the Grand Rapids office for appointments in Grand Rapids, Traverse City or Mason or to the Kalamazoo office for appointments in Kalamazoo.

DATE: _____

TO: The Fertility Center – New Patient Paperwork Processing

FAX #: Grand Rapids – (616) 988-2010
Kalamazoo – (269) 324-5041

FROM: _____

NUMBER OF PAGES INCLUDING THIS COVER PAGE: ____

Notes:_____

_____

_____

_____

_____

_____

Appointment Date: _____ Office Location:

Patient

Legal First Name: _____ Middle Initial: _____ Last Name: _____ Maiden Name: _____

Preferred First Name: _____ Preferred Pronouns: Date of Birth: _____ Age: _____

SS#: XXX-XX-_____ Marital Status: Military Status/Branch: _____

Gender (optional): Race (optional): _____ Ethnicity (optional): _____

A *detailed* voice message may be left at the following phone number: (___)_____

Street Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Employment Status: ☐ Full Time ☐ Part Time ■ NA

Employer: _____ Address: _____ City: _____ State: ____ Zip: _____

Employer Phone Number: (___)_____ Date Employed: _____ to _____

Emergency Contact: _____ Phone Number: (___)_____ Relationship:

Alternate Emergency Contact: _____ Phone Number: (___)_____ Relationship:

Referring Physician: _____ Telephone Number: (____)_____

Family Physician: _____ Telephone Number: (____)_____

Spouse/Partner - Please select the following: Spouse ☐ Partner ☐ No Partner ☐

Legal First Name: _____ Middle Initial: _____ Last Name: _____ Maiden Name: _____

Preferred First Name: _____ Preferred Pronouns: Date of Birth: _____ Age: _____

SS#: XXX-XX-_____ Marital Status: Military Status/Branch: _____

Gender (optional): Race (optional): _____ Ethnicity (optional): _____

A *detailed* voice message may be left at the following phone number: (___)_____

Street Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Employment Status: ☐ Full Time ☐ Part Time ■ NA

Employer: _____ Address: _____ City: _____ State: ____ Zip: _____

Employer Phone Number: (___)_____ Date Employed: _____ to _____

Emergency Contact: _____ Phone Number: (___)_____ Relationship:

Alternate Emergency Contact: _____ Phone Number: (___)_____ Relationship:

Referring Physician: _____ Telephone Number: (____)_____

Family Physician: _____ Telephone Number: (____)_____

How did you hear about The Fertility Center? (Please check all that apply)

☐ **Friend/Family Member** ☐ **Internet Search** **Social Media:** ☐ Facebook ☐ Instagram ☐ **Other:** _____

☐ **Referred by a Physician**

Physician Name: _____ Specialty: _____

City: _____ State: _____ Zip: _____ Phone Number: (____)_____

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Limited Patient Authorization for Disclosure of Protected Health Information (PHI) to an Individual

Please print all information. Authorization is in effect for 12 months with a mandatory requirement of updating annually unless an earlier termination date is specified.

Patient Name: _____ Partner to: _____

'Patient' refers to the person completing this form

Patient Social Security Number: XXX-XX-_____ Patient Date of Birth: _____

I authorize the practice (*Michigan Reproductive and IVF dba The Fertility Center*) to disclose or provide protected health information about me to the individual(s) listed below.

The following individuals will be authorized to receive information (list each family member, friend, or other individual to receive PHI):

Name: _____ Phone: _____ Relationship:

Name: _____ Phone: _____ Relationship:

I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ **Entire patient record**

Or check only those items of the record to be disclosed:

☐ office notes ☐ lab results ☐ imaging reports ☐ financial history report (previous 3 years only)

☐ HIV and communicable disease testing results ☐ record of mental health or substance abuse treatment

Purpose of disclosure:

☒ Patient Request ☐ Other (please specify): _____

Expirations or termination of authorization and right to revoke or terminate this authorization: This authorization will expire 12 months from the date of your last signature below unless you specify an earlier termination. You must renew or submit a new authorization after the date of your last signature to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. ***Please list date of expiration if earlier than 12 months from date of last signature)***: _____.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice. You have the right to receive a copy of signed authorizations upon request.

_____ _____(expires in 12 months)

Patient signature Date

FINANCIAL POLICY

Insurance coverage for infertility varies. Many insurance companies do not cover infertility. For this reason, we ask that you pay all fees at the time of service. We are not able to offer payment arrangements for any services. Financing is available through Advance Care Card. Please contact the billing department for more information.

We will submit a claim as a courtesy for all services rendered except for Tricare, VA, BCN Lab Services, Medicaid, and Aetna. If you are an Aetna patient, we will issue an itemized receipt for you to submit to Aetna for reimbursement. Please provide us with your current insurance information. If your insurance changes, please update us as soon as possible to ensure your claim is submitted correctly and promptly. **Please note that your insurance policy is a contract between you and your insurance company; therefore, it is your responsibility to know and understand your contractual obligations and limitations.**

During the course of your treatment at The Fertility Center, you may wish to have a telephone consult. Telephone consults are billed to your insurance and are sometimes not covered and would then be your responsibility.

During your treatment plan, should you have an ultrasound at another facility, there is a $115 per cycle outside monitoring fee that is not billable to your insurance company.

Should you be interested in pursuing Assisted Reproductive Technologies (ART), you must initially pay a non-refundable ART Cycle Management fee in order to reserve a month for your procedure. Your complete ART fee **must** be prepaid prior to your procedure. A financial consult will be completed such that you will have a better understanding of the costs of your procedure(s).

In some cases, surgery may be recommended. We will bill your insurance for this. However, if you have insurance that we do not participate with, you will be required to pay in full within 30 days of the procedure.

Any outstanding balances must be resolved prior to beginning each treatment cycle. However, in the event of an emergency, care will be provided regardless of outstanding financial obligations.

Failure to pay any balances in a timely manner will result in a referral to a collection agency. In addition to the effect collection action will have on your credit rating, future services by The Fertility Center will not be provided until the balance is paid in full.

When obtaining a copy of your personal medical record for services rendered by The Fertility Center, we do not institute a monetary charge for the dissemination of a single copy of your record. A request for two or more copies of your personal medical record is subject to a $25.00 administrative fee. There is a $35.00 fee for FMLA paperwork.

For your convenience, we accept the following forms of payment: cash, check, credit card, and money order. Online bill payment is an option via our website, fertilitycentermi.com. We charge a service fee of $25.00 for all returned checks. **All office fees are approximate and subject to change without notice.**

No Show policy: We require 48 hours' notice to cancel an appointment. You will be charged ½ the visit cost if you fail to show or contact the office. You will be charged $25.00 if you contact the office in less than 48 hours. There will be no charge if you cancel with a 48-hour notice. For self-pay and non-par insurances, a $100 deposit is required when making a new patient or established patient appointment. There is a $50 no show fee for retrograde appointments in our lab.

Should you have any questions, please feel free to contact our office at (616) 389-8709 or (616) 988-2229, option 5.

Acknowledgement of Payment Responsibility

I have read and understand the Financial Policy of The Fertility Center and agree to its terms. I understand that I am financially responsible for any services provided by The Fertility Center, including any items denied or not covered by my insurance and any yearly deductible or co-payment amounts. I acknowledge all outstanding balances for services are to be resolved within 30 days.

Print Name: _____ DOB: _____

Signature: _____ **Date:** _____

(Patient or Parent/Guardian if minor)

Notice of Privacy Practices: I acknowledge that I have received a copy of the Notice of Privacy Practices: _____

Patient initials

The Fertility Center

William Dodds MD, Valerie Shavell MD,
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CONSENT FOR TREATMENT

Knowing that I require diagnostic testing, medical treatment or hospitalization, I voluntarily consent to the medical treatment deemed necessary in the judgment of my treating physicians. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of examination, tests, or treatments. I understand that if major diagnostic studies or treatment procedures such as surgery are required, I will be asked to give specific consent to those procedures. If I am an obstetrical patient, I understand that my signature consents to the care and treatment of my fetus.

MY MEDICAL INFORMATION

I understand that The Fertility Center will keep my medical information according to state law, federal law, and policy. I also understand that my information will be stored electronically and may be sent to or received from other healthcare providers and/or payers electronically. This includes treatments and medicine or prescription information about me, including drug or alcohol use. In some cases, The Fertility Center is required by law to report information to an agency like the health department. This may prevent other diseases. I understand I can ask additional questions before signing this consent.

I have read the above information or have had it explained to me, and indicate my understanding of same, by signing this document.

**Please note: 'Patient Name' refers to the person completing this form.*

_____ _____
Patient Name (Please Print) DOB

_____ _____
Patient Signature Date

_____ _____
The Fertility Center Staff Witness Date

If this consent form is not signed in the presence of a member of The Fertility Center staff, form **must be notarized below:*

Notary Public _____ County, Michigan
Acting in the County of _____
Signature _____
My commission expires:

The Fertility Center

William Dodds MD, Valerie Shavell MD,
Mili Thakur MD, Emma Giuliani MD

CONSENT FOR HIV TESTING

HIV (Human Immunodeficiency Virus) infection is a long-term illness that damages the body's immune system and its ability to fight diseases. HIV can cause AIDS (Acquired Immunodeficiency Syndrome), the stage of HIV when the body is weakened and less able to fight off germs. HIV spreads through blood, semen, vaginal fluids, and breast milk. You can get or give an HIV infection by having vaginal, anal, or oral sex without a condom or sharing needles when injecting drugs. An infected mother can pass HIV to her child during pregnancy, birth or breastfeeding. You cannot get HIV by donating blood or through casual contact like hugging or shaking hands. People can have HIV for years and not know it unless they get tested. Testing to determine if you **are infected** will help to facilitate proper treatment.

HIV testing: A **negative result** means you are not infected with HIV or you may have a recent infection that is too early to show up positive. If you have been exposed to HIV in the last six weeks, the test may not detect a new infection. A **positive result** means you are living with HIV. This means you can pass your infection to others through sex, sharing needles, or through birth or breastfeeding. You should take precautions to avoid infecting others.

I understand I can ask additional questions before signing this consent and may ultimately refuse to sign it. My physician will review my treatment options at The Fertility Center, should I refuse HIV testing. I understand HIV test results are confidential and shall not be released without my permission, except as permitted under state law. I understand that I have a right to have this test done without the use of my name at any Michigan Department of Health-approved HIV counseling and testing site.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results. I understand that I have the right to withdraw my consent for the test at any time before the test is complete. By my signature below, I consent to be tested for HIV.

☐ I consent to HIV Testing.
☐ I do not consent to HIV Testing

_____ _____
Patient Signature Date

**Please Note: Our credentialing agencies require that all In Vitro Fertilization (IVF) patients complete this test.*

I have read the above information or have had it explained to me, and indicate my understanding of same, by signing this document.

**Please note: 'Patient Name' refers to the person completing this form.*

_____ _____
Patient Name (Please Print) DOB

_____ _____
Patient Signature Date

_____ _____
The Fertility Center Staff Witness Date

If this consent form is not signed in the presence of a member of The Fertility Center staff, it **must be notarized below:*

Notary Public _____ County, Michigan
Acting in the County of _____
Signature _____
My commission expires:

Genetic Information Acknowledgement

Patient Name: _____ Patient Date of Birth: _____

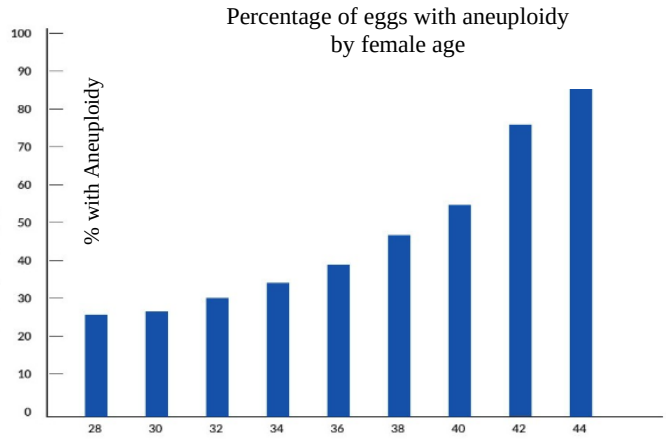
Partner Name: _____ Partner Date of Birth: _____

The purpose of this document is to confirm that The Fertility Center (Michigan Reproductive & IVF Center, P.C.) has provided the patient with information regarding genetic risks and testing options prior to treatment.

1. **Preconception Genetic Carrier Screening for Inherited Conditions**
   - Purpose of test: Identify individuals and reproductive partners at increased risk of passing certain serious genetic conditions on to their children. Testing before pregnancy enables family planning options and/or preparation. Most carriers do not have clinical symptoms or a family history of the condition. If you have specific familial genetic risks, a genetic counseling appointment is recommended prior to testing.
   - Rationale: We offer genetic screening based on current recommendations from Ob/Gyn and Genetics professional societies, but the decision to have carrier screening is a personal choice.
   - Process: As over 70% of people are identified as carriers with this test, sending both partners' samples (if applicable) at the same time will give the most efficient meaningful results. Otherwise, if the first person tested is positive, partner testing is recommended to determine the chance of having an affected child. Results take 2-3 weeks.
     - Saliva or blood sample is collected for this test. *It is your responsibility to let our staff know if you desire testing today or in the future.*

   Further details about carrier screening are included in the folders given to you and on our website.

2. **Preimplantation Chromosome Screening**
   - Any pregnancy is at risk for an abnormal number of chromosomes in the embryo(s). This is called aneuploidy. Most aneuploid embryos will not implant or will miscarry, with aneuploidy accounting for 50-70% of first trimester losses. Extra or missing chromosomes can also lead to a variety of health and developmental concerns in a child. The chance of aneuploidy increases with maternal and paternal age.
   - Multiple screening and diagnostic tests for chromosome abnormalities are available during pregnancy. Chromosome screening prior to embryo transfer is an option available through Preimplantation Genetic Testing for Aneuploidy (PGT-A) during an In Vitro Fertilization cycle.
   - It is your responsibility to let your physician know if you are interested in PGT-A.



ACKNOWLEDGEMENT: By signing below, the patient (and partner if applicable and present) acknowledges having read and understood the above information prior to beginning fertility treatment at The Fertility Center. Genetic counseling is available if you wish to discuss these options further.

SIGNATURE(S):

Patient Printed Name	Patient Signature	Date
Partner Printed Name (if applicable and present)	Partner Signature (if applicable and present)	Date
Printed Name of Staff Member	Signature of Staff Member	Date

The Fertility Center

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317 S. Drake Road Suite B
Kalamazoo, MI 49009
269-324-5100

1100 S Cedar Street Suite 2
Mason, MI 48854
877- 904-4483

Physicians: William Dodds, MD
Valerie Shavell, MD
Mili Thakur, MD
Emma Giuliani, MD

Patient Name: _____

Patient Date of Birth: _____

Review of Systems/Medical History

Do you consistently have any of the problems listed below that are not currently being treated or evaluated by another physician? Please check **Yes** or **No** and explain any Yes answers in the space provided.

Constitutional Symptoms	YES	NO
Activity change	☐	☐
Appetite change	☐	☐
Chills	☐	☐
Sweating at night	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Unexpected weight loss	☐	☐
Other_____		

HEENT	YES	NO
Ear discharge	☐	☐
Hearing loss	☐	☐
Ear pain	☐	☐
Ears ringing	☐	☐
Nosebleeds	☐	☐
Congestion	☐	☐
Runny nose	☐	☐
Sneezing	☐	☐
Sore throat	☐	☐
Hoarse voice	☐	☐
Other _____		

Eyes	YES	NO
Eye discharge	☐	☐
Eye itching	☐	☐
Eye pain	☐	☐
Eye redness	☐	☐
Light sensitivity	☐	☐
Vision changes	☐	☐
Other _____		

Cardiovascular	YES	NO
Chest pain	☐	☐
Palpitations/racing heart	☐	☐
Difficulty breathing while lying down	☐	☐
Leg pain with walking	☐	☐
High cholesterol	☐	☐
Other _____		

Gastrointestinal	YES	NO
Trouble swallowing	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Abdominal pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Fecal incontinence	☐	☐
Rectal pain	☐	☐
Rectal bleeding	☐	☐
Blood in stool	☐	☐
Other _____		

Genitourinary	YES	NO
Flank pain	☐	☐
Urinary incontinence	☐	☐
Blood in urine	☐	☐
Painful urination	☐	☐
Difficult urination	☐	☐
Urinary frequency	☐	☐
Menopausal symptoms	☐	☐
Heavy menses	☐	☐
Painful menses	☐	☐
Other _____		

Musculoskeletal	YES	NO
Neck pain	☐	☐
Back pain	☐	☐
Joint pain/swelling	☐	☐
Muscle pain	☐	☐
Gait problems/falls	☐	☐
Osteoporosis	☐	☐
Other _____		

Neurological	YES	NO
Headaches	☐	☐
Dizziness/lightheaded	☐	☐
Speech difficulty	☐	☐
Loss of consciousness	☐	☐
Seizures/tremors	☐	☐
Numbness/tingling	☐	☐
Weakness	☐	☐
Other _____		

Endo/Heme/Aller	YES	NO
Blood transfusions	☐	☐
Enlarged lymph nodes	☐	☐
Bruise/bleed easily	☐	☐
Env. allergies	☐	☐
Excessive thirst	☐	☐
Frequent thirst	☐	☐
Other _____		

Psychiatric	YES	NO
Depression	☐	☐
Suicidal ideas	☐	☐
Anxiety	☐	☐
Hallucinations	☐	☐
Self-injury	☐	☐
Sleep disturbance	☐	☐
Hyperactivity	☐	☐
Behavior problems	☐	☐
Decreased concentration	☐	☐
Other _____		

Skin	YES	NO
Itching	☐	☐
Color change	☐	☐
New/changed spots	☐	☐
Rash	☐	☐
Wound	☐	☐
Nail changes	☐	☐
Hair changes	☐	☐
Breast pain	☐	☐
Breast mass/lump	☐	☐
Nipple discharge	☐	☐
Other _____		

Respiratory	YES	NO
Cough	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐
Chest tightness	☐	☐
Snoring	☐	☐
Choking	☐	☐
Phlegm/mucous production	☐	☐
Other _____		

_____ _____

Patient Name (Print and Sign) Date

_____,MD, DO _____

Signature of Physician Date

The Fertility Center

William Dodds MD, Valerie Shavell MD,
Mili Thakur MD, Emma Giuliani MD

PATIENT

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Height: _____ Weight: _____

CURRENT MEDICATION LIST *including all vitamins and supplements*

Medication	Frequency & Dose	Medication	Frequency & Dose

PREFERRED PHARMACY

Pharmacy Name _____ Phone Number _____ Fax Number _____

Street Address _____ City _____ ST _____ Zip code _____

ALLERGIES

Allergic to	Reaction	Allergic to	Reaction

MEDICAL HISTORY

Diabetes	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO
Abnormal Pap	☐ YES	☐ NO	HIV+	☐ YES	☐ NO
Endometriosis	☐ YES	☐ NO	Pain with intercourse	☐ YES	☐ NO
Pelvic Pain	☐ YES	☐ NO	Sexually transmitted infections	☐ YES	☐ NO

Other medical conditions (please specify): _____

PATIENT cont.

SURGICAL HISTORY

Date	Type of Procedure		
_____	Hysterosalpingogram (HSG)	☐ YES	☐ NO
_____	Intrauterine Insemination (IUI)	☐ YES	☐ NO
_____	In Vitro Fertilization (IVF)	☐ YES	☐ NO

If yes:

How many retrievals? _____ How many eggs retrieved? _____

How many embryo transfers? _____ Did you become pregnant? ☐ YES ☐ NO

Do you have any embryos left? _____

Additional Surgeries:

Date	Type of Procedure
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Relationship	Alive/Deceased	Cancer (please specify type)	Infertility or Recurrent Pregnancy Loss	Other Diseases, including Genetic Conditions
Paternal GF			☐	
Paternal GM			☐	
Maternal GF			☐	
Maternal GM			☐	
Father			☐	
Mother			☐	
Brother(s)			☐	
Sister(s)			☐	
Other			☐	

SUBSTANCE USE

*Are you **currently** using any of the following?*

Cigarettes ☐ YES ☐ NO

Electronic Cigarettes, Pipes, Cigars, Vapor with Nicotine, Smokeless Tobacco ☐ YES ☐ NO

If yes, please specify type: _____

Frequency: ☐ Every Day ☐ Some Days

If every day, how many packs or times/day: _____ Start date: _____

Drug use, including marijuana ☐ YES ☐ NO

Did you ***formerly*** use any of the above products? ☐ YES ☐ NO

If yes, please list: _____

Start date: _____ Quit date: _____

PATIENT cont.

ALCOHOL USE

Do you drink alcohol? ☐ YES ☐ NO

Frequency: _____

SEXUAL ACTIVITY

Sexually active: ☐ YES ☐ NO ☐ NOT CURRENTLY

Gender of Partner(s): ☐ MALE ☐ FEMALE ☐ TRANSGENDER

Using birth control/protection? ☐ YES ☐ NO

If yes, type of birth control/protection: _____

SOCIOECONOMIC

Current Employer: _____Occupation: _____

MARITAL STATUS

Marital Status: _____

Married/committed since (year): _____

Spouse/Partner Name: _____

FERTILITY HISTORY

What is your reason for seeking fertility testing/treatment)? _____

Who has referred you to our practice? _____

How long have you been trying to get pregnant? _____

Birthplace: _____

Have you been treated for infertility? ☐ YES ☐ NO

If yes, by whom? _____

Have you used ovulation predictor kits? ☐ YES ☐ NO

Have you used basal body temperature charts? ☐ YES ☐ NO

Have you been diagnosed with PCOS? ☐ YES ☐ NO

Have you been diagnosed with endometriosis? ☐ YES ☐ NO

Do you have a history of uterine polyps or fibroids? ☐ YES ☐ NO

Have you used Femara (letrozole)? ☐ YES ☐ NO

If yes, when? _____ How many cycles? _____ Dosage for each cycle? _____

Have you used Clomid (clomiphene)? ☐ YES ☐ NO

If yes, when? _____ How many cycles? _____ Dosage for each cycle? _____

Do you feel safe at home? ☐ YES ☐ NO

Does anyone threaten or physically hurt you? ☐ YES ☐ NO

PATIENT cont.

MENSTRUAL HISTORY

Age of first period: _____ Period Pattern: ☐ Regular ☐ Irregular

Number of days you bleed: _____ Number of days between each cycle: _____ Last Menstrual Period (LMP): _____

OBSTETRIC HISTORY (List all confirmed pregnancies and deliveries)

Total number of pregnancies: _____ Total number of biological children: _____

Number of Miscarriages: _____ Date(s): _____ _____ _____ _____

Date(s): _____ _____ _____ _____

Additional Information: _____

Number of Ectopic Pregnancies: _____ Date(s): _____ _____ _____ _____

Additional Information: _____

Delivery Information:

Date	Weeks Gestation	Delivery Type *Vaginal or Cesarean*	Complications, if any
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Routine gynecological care and mammography screening are very important to a woman's health. The American College of Obstetricians and Gynecologists (ACOG) recommends that most women should be screened for cervical cancer no more often than once every three to five years depending on the woman's age and past screening results. ACOG and the American Cancer Society also recommend mammography screening annually for women beginning at age 40 (ACOG) and 45 (American Cancer Society). The Fertility Center follows these recommendations, along with the recommendations of your gynecologist or primary care provider, as to how often you should have a Pap smear, breast exam, well woman's checkup, and mammography screening. The Fertility Center does not provide or order routine gynecological care or mammograms. These procedures should be scheduled with your gynecologist or primary care provider and kept current as per ACOG, American Cancer Society, and your provider's recommendations.

By signing below, I agree that I am current on these exams and will continue to follow the advice of my gynecologist or primary care provider.

_____ _____
Patient Name (Print) Date of Birth

_____ _____
Patient Signature Date Signed

Questions for your TFC Physician

We understand that this process can be overwhelming. You likely have many thoughts and questions running through your mind, and it's easy to forget to ask some of the big things you were hoping to have answered.

In an effort to prevent this from happening, and to make the best use of your time at your new patient appointment, we would like to provide a space for you to compile your thoughts and questions prior to meeting with your physician.

This form is for your use only. You do not need to return this with your new patient paperwork.