Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

REGISTRATION
(Please Print)

Date: __/__/____ Home Phone: _____
Patient_____
Last Name First Name Initial
Responsible Party (if a minor)_____
Street Address: _____
City_____State_____Zip _____
Sex _ M _ F Age __ Birthdate_____ Single __Married __ Widowed __ Separated __ Divorced
Patient Employed By _____
Business Address_____
Occupation _____Business Phone _____
Spouse (or responsible party) Name _____ Birthdate _____
Business Name and Address _____
Occupation_____ Business Phone _____
Who is responsible for this account? _____Relationship to Patient _____
Social Security #_____Spouse's Social Security # _____
Do you have Medical Insurance? __ No __ Yes __ If yes,
Name of Primary Insurer _____
Contract# _____Group #_____Subscriber# _____
Name of Secondary Insurer (if any)_____
Contract# _____Group#_____ Subscriber# _____
__ Medicare __ Medicaid Claim ID# _____
If Welfare, your number _____County of _____
In case of emergency, who should be notified? _____ Phone _____
How did you learn of our practice? _____

Assignment and Release

I, the undersigned, have Insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. _____all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____
Signature of Insured/Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as though full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Please Print Clearly

Identifying Data

Date __/__/____

Your name _____Partner's name_____
Your Age _____ Birthdate_____ Height _____ Weight _____
Your occupation _____
Years of formal education _____
Length of marriage (or relationship) _____
How long have you been trying unsuccessfully to get pregnant? _____
Have you previously tried to get pregnant? _____
Reason for your visit today _____
Do you have a Gynecologist? If yes, who? _____
When was your last pap smear? Date _____ Mammogram? Date _____
Pregnancy History
Times pregnant _____ Term births _____Premature births _____ Miscarriages _____
Elective abortions _____ Adopted Children _____

Date	Miscarriages	Elective abortion	Months to conceive	Infertility treatment	Weight and sex	Complications or c-section	Is current partner father
1.							
2.							
3.							
4.							
5.							

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Contraceptive Use

Type	From when to when	Reason discontinued
1.		
2.		

Operations and Hospitalizations

	Date	Diagnosis	Operation	Where Performed	Physician
1.					
2.					
3.					
4.					

Medication:
Please list all prescriptions and over-the-counter drugs used during the past year.

Drug	Dosage and Frequency	From when to when	Reason for taking
1.			
2.			
3.			
4.			
5.			

Allergies

	To what drug or substance	When	Reaction
1.			
2.			
3.			

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Menstrual (hormonal) history

First day of actual flow not spotting, of your last menstrual period _____
Your age at your first period _____
Are your periods regular? _____
How many days from onset to onset?_____
How many days does your period last? _____
Do you bleed between periods? _____
Do you have premenstrual symptoms __ Almost always __ Rarely __ Never
Vigorous exercise type _____
If you have hormonal disorder, please specify type and treatment _____
_____
Have you or your partner traveled outside of the U.S. in the last six months? __ Yes __ No
Pelvic pain/cramps __ None __ during your period __ before your period __ after your period
__ at mid cycle __ during intercourse __ with urination __ with bowel movement

Pelvic pain/cramps are: __ mild __ moderate __ severe __ getting worse __ improving
__ not changing
__ on the right side __ on the left side __ in the middle

Do you have or have you had:

Hot flashes	__ Yes __ No	Increased facial or body hair	__ Yes __ No
Breast discharge	__ Yes __ No	Increased acne	__ Yes __ No
Vision problems	__ Yes __ No	Weight gain greater than 10 pounds	__ Yes __ No
Poor sense of smell	__ Yes __ No	Weight loss greater than 10 pounds	__ Yes __ No
Chronic headache	__ Yes __ No	Special dietary habits	__ Yes __ No
Head injury	__ Yes __ No	Vomiting	__ Yes __ No
Seizures	__ Yes __ No	Autoimmune	__ Yes __ No
Thyroid Disorder	__ Yes __ No	Psychiatric treatment	__ Yes __ No
Excessive stress	__ Yes __ No	Diabetes	__ Yes __ No

If you answered yes to any questions, please explain _____
_____
_____
_____

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Physical Conditions/Infections

Do you have or have you had:

Pelvic infection	__ Yes __ No	Abnormal Uterus	__ Yes __ No
Chlamydia	__ Yes __ No	Colitis or enteritis	__ Yes __ No
Antichlamydial antibodies	__ Yes __ No	Endometriosis	__ Yes __ No
Gonorrhea	__ Yes __ No	Pelvic adhesions	__ Yes __ No
Syphilis	__ Yes __ No	Ovarian cyst	__ Yes __ No
Mycoplasma	__ Yes __ No	Uterine fibroids	__ Yes __ No
Ureaplasma	__ Yes __ No	Toxoplasmosis	__ Yes __ No
Tuberculosis	__ Yes __ No	DBS exposure	__ Yes __ No
Cytomegalovirus	__ Yes __ No	In womb	__ Yes __ No
Cervicitis	__ Yes __ No	Recurring vaginitis	__ Yes __ No
Genital herpes	__ Yes __ No	Abnormal pap smears	__ Yes __ No
Genital warts/ Condyloma	__ Yes __ No	Cryo (freezing) or	
Trichomas	__ Yes __ No	surgery of the cervix	__ Yes __ No

How many times per week do you have sexual intercourse? _____
How many times do you have intercourse around ovulation? _____
Do you use lubricants for intercourse? If yes, what? _____
Do you douche before or after intercourse? _____
Number of current sexual partners: _____
Number of total past sexual partners: _____
Have you ever tried conceiving with another partner ? __ Yes __ No
Problems with conceiving in your previous relationship? __ Yes __ No

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Other Medical History

Cigarettes – packs smoked per day _____
Alcohol – type and number of drinks/week _____
Marijuana – amount _____
Other drug – type and amount _____
Ever used Intravenous drugs _____
Caffeine drinks _____
Radiation Exposure _____
Toxic Exposure _____
Electric blanket use _____
List all serious or chronic illnesses or injuries not already described _____
_____
_____
_____
_____

Do you or your family
members have: __ Infertility __ Hormonal disorder __ Other inherited disorders

If yes, please explain _____
_____
_____
_____
_____
_____

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Partner's Medical History

Your partner's age _____ Occupation _____
List all serious or chronic illness or injuries _____
Medications _____
Cigarettes – packs smoked per day _____
Alcohol – type and number of drinks/week _____
Marijuana – amount _____
Other drug – type and amount _____
Ever used Intravenous drugs _____
Caffeine drinks _____
Radiation Exposure _____
Toxic Exposure _____
Electric blanket use _____
Hot tub or sauna use _____
Any problems with erection or ejaculation _____
Has a semen analysis ever been abnormal _____
Has your partner seen a doctor for infertility evaluation _____
Doctor _____
Diagnosis _____
Treatment _____

Has your partner ever initiated any pregnancies in the past? __ Yes __ No
Number of pregnancies? _____
Number with current partner ? _____
When was the most recent pregnancy? _____
Number of current sexual partners? _____
Number of total past sexual partners? _____
How many times per week does your partner have sexual intercourse? _____
Has your partner ever tried conceiving with another partner before? _____
Problems with conceiving in previous relationship? _____
Any inherited diseases in your partner's family? _____
_____
Have you or your partner traveled outside of the U.S. in the last six months? __ Yes __ No

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Partner's Medical History (Continued)

Does your partner have or has he had:

Chlamydia	__ Yes __ No	Vasectomy	__ Yes __ No
Antichlamydial antibodies	__ Yes __ No	Vasectomy reversed	__ Yes __ No
Gonorrhea	__ Yes __ No	Varicocele	__ Yes __ No
Syphilis	__ Yes __ No	Varicocele surgery	__ Yes __ No
Mycoplasma	__ Yes __ No	Biopsy of testicles	__ Yes __ No
Ureaplasma	__ Yes __ No	Hernia surgery	__ Yes __ No
Tuberculosis	__ Yes __ No	Abdominal surgery	__ Yes __ No
Cervicitis	__ Yes __ No	Cancer	__ Yes __ No
Genital herpes	__ Yes __ No	High blood pressure	__ Yes __ No
Genital warts/ Condyloma	__ Yes __ No		
Diabetes	__ Yes __ No	Colitis	__ Yes __ No
Urethritis/ Epididymitis	__ Yes __ No	Seizures	__ Yes __ No
Prostatitis	__ Yes __ No	Psychiatric treatment	__ Yes __ No
Penile discharge or pain	__ Yes __ No	Excessive stress	__ Yes __ No
Undescended testicles	__ Yes __ No	Strenuous exercise	__ Yes __ No
Injury to testicles	__ Yes __ No	Tight underwear	__ Yes __ No
Mumps with injury to testicles	__ Yes __ No	Physical abnormality	__ Yes __ No
DES exposure in womb	__ Yes __ No		

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Previous Treatment

Treatment	Patient	Partner	How many months	Dosage (if known)	Approx. dates taken
Antibiotics:	_____	_____	_____	_____	_____
Name of:	_____	_____	_____	_____	_____
Provera – (to bring on menses)	_____	_____	_____	_____	_____
Clomiphene (Clomid)	_____	_____	_____	_____	_____
hCG (Profasi)	_____	_____	_____	_____	_____
Progesterone in Oil	_____	_____	_____	_____	_____
Crinone 8% gel	_____	_____	_____	_____	_____
Follistim	_____	_____	_____	_____	_____
Gonal-F	_____	_____	_____	_____	_____
Pergonal	_____	_____	_____	_____	_____
Repronex	_____	_____	_____	_____	_____
Lupron 2 week kit	_____	_____	_____	_____	_____
Lupron monthly dose	_____	_____	_____	_____	_____
Intrauterine Insemination	_____	_____	_____	_____	_____
Insemination with Donor sperm	_____	_____	_____	_____	_____
IVF	_____	_____	_____	_____	_____
ICSI	_____	_____	_____	_____	_____
GIFT	_____	_____	_____	_____	_____

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Financial Agreement

I am aware I am responsible for understanding the rules and regulation of my insurance company. Therefore, it is my responsibility to obtain any and all required authorizations from my primary care physician if necessary. I agree to be responsible for any and all charges incurred as a result of not obtaining the appropriate referral prior to my office visit. Furthermore, if at any time, the claims submitted to my insurance company are rejected for any reason, I agree to be responsible for all charges and payments. I understand that this includes being fully responsible for any balance, which may remain after insurance payments.

I understand that any supplies or medications obtained from the office of Jacob L. Glock, M.D. must be paid for at the time of service. The office will provide me with a receipt to submit to my insurance company claims office.

I agree to immediately inform the office of Jacob L. Glock, M.D. of any changes in my insurance status.

I agree to make the office of Jacob L. Glock, M.D. aware of any rider exclusions to my insurance coverage; i.e., pre-existing conditions.

I further understand that after reasonable attempts by the office of Jacob L. Glock, M.D. to collect on my account, should my account be turned over to an outside collection agency, I will not only be responsible for the unpaid balance but the cost of collection efforts as well.

I authorize the release of any medical information necessary to process all claims incurred in the office of Jacob L. Glock, M.D.

I authorize payment of medical benefits to the office of Jacob L. Glock, M.D. for all supplies and services rendered.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Witness

Jacob L. Glock, M.D.
15730 New Hampshire Court, Unit 101
Fort Myers, FL 33908
239-561-3430 Fax 239-561-6980

Patient Name: _____

Account Number: _____

Semen Analysis

I have been advised that the office of Jacob L. Glock, M.D. does not accept insurance payment for semen analysis nor will they bill insurance for semen analysis testing. I have been advised that if I have benefits for this service and I choose to utilize these benefits under my insurance, I will be given a laboratory order for this testing to be performed at an outside laboratory with the results being sent to the office of Jacob L. Glock, M.D. I further understand, should I elect to have this testing performed at an outside laboratory, the office of Jacob L. Glock, M.D. cannot guarantee the integrity of these results.

I have been advised that the fee for this service is $160.00 and is due in full prior to the analysis being performed at the office of Jacob L. Glock, M.D. I further understand that should an outside office request this analysis, without first being established as a patient of Jacob L. Glock, M.D., my results will be sent to the requesting physician and I will be notified of the results by my personal physician.

Finally, I have been advised that this acknowledgment will stand for any and all subsequent semen analysis performed by the office of Jacob L. Glock, M.D.

_____ _____

Patient Signature Date

_____ _____

Witness Date

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PLEASE READ CAREFULLY

To: Physician: _____
Address: _____
City/State/Zip: _____
Phone: _(__)_____
Fax: _(__)_____

You are hereby authorized to release and disclose the information form my medical record. I agree to the release and/or faxing of all of my medical records including records pertaining to HIV, sexually transmitted diseases, drug/alcohol abuse and psychiatric records to Jacob L. Glock, M.D.

Patient Name: _____ Date of Birth _____
Social Security Number: _____ Medical Record Number _____

Please include (Patient must initial each request)

____ Physician / Nurse / Staff Notes and/or Dictation
____ Pertinent X-Ray copies and/or Narratives
____ Lab Values, Including HIV and Hepatitis
____ Pathology Reports
____ Operative Reports
____ Psychiatric Records
____ Medical Records from other Physicians contained within my chart
____ Other: _____

Forward Medical Records for:

Jacob L. Glock, M.D.
15739 New Hampshire Court, Unit 101
Ft. Myers, FL 33908
239-561-3430 Fax 239-561-6980

_____ _____
Signature of Consenting Party Date

_____
Relationship if other than patient

_____ _____
Witness Date