

PRE-CONCEPTION COUNSELING SURVEY

PATIENT NAME: _____

D.O.B. _____

Please answer the following questions and forward to Tepeyac Family Center, LLC at least 5 business days prior to your scheduled appointment. You may email the completed form to: info@tepeyacfamlycenter.com (the subject line should be: Pre-Conceptual Counseling Appointment – Attn: Allyson or Julie) or fax to (703) 273-9445 (attn: Allyson or Julie) or mail to Tepeyac Family Center, 11135 Lee Highway, Fairfax, VA 22030. You may contact our staff at (703) 273-9440 x 106. Thank you.

Has it been at least 12 months since you have been having unprotected sex with your spouse without conception?

Yes No Other: _____

FEMALE PARTNER

1.) Age _____

2.) Number of Previous Pregnancies _____

3.) Date(s) & Outcome of Prior Pregnancies

____/____/____

____/____/____

____/____/____

____/____/____

4.) Is there a history of voluntary sterilization or reversal? Yes No

MALE PARTNER

1.) Age _____

2.) Has he fathered any previous pregnancies? Yes No

3.) Were these with the present partner? Yes No

4.) Is there a history of voluntary sterilization or reversal? Yes No

PLEASE NOTE THAT SOME INSURANCE COMPANIES REQUIRE THAT SOME TESTING BE DONE PRIOR TO YOUR APPOINTMENT WITH US. YOU MAY NEED A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN FOR THOSE TESTS AND FOR CONSULT AND TREATMENT AT OUR OFFICE AS WELL. INFERTILITY SERVICES, IF COVERED BY YOUR INSURANCE, MAY REQUIRE A REFERRAL EVEN THOUGH ORDINARY GYN SERVICES DO NOT. IF PRIOR TESTING IS REQUIRED, THE RESULTS SHOULD BE FORWARDED TO US SO THAT WE CAN SUBMIT THEM TO YOUR INSURANCE COMPANY ALONG WITH A COPY OF THIS QUESTIONNAIRE IN ORDER TO OBTAIN AUTHORIZATION. IF A SEMEN ANALYSIS IS REQUIRED TO OBTAIN AUTHORIZATION, PLEASE CONTACT OUR OFFICE FOR AN "SA Kit". YOUR PCP WILL NEED TO ORDER THIS TEST.

PLEASE COMPLETE THE INSURANCE INFORMATION BELOW SO THAT WE CAN CONTACT THEM TO VERIFY YOUR INFERTILITY BENEFITS.

INSURANCE NAME _____ BENEFITS PHONE # _____

AUTHORIZATION PHONE # _____ SUBSCRIBER _____

SUBSCRIBER DOB _____ ID# _____ GROUP # _____

