NEW LIFE AGENCY
Insurance Agency
A New World of Insurance

Assisted Reproduction Insurance Program®

New Life Agency, Inc. Lloyd's Coverholder
41-750 Rancho Las Palmas Drive • Suite N-3 • Rancho Mirage, CA 92270
Tel (877) 952-5433(LIFE) • Fax (877) 952-5589

FEMALE PATIENT HISTORY
I. IDENTIFYING INFORMATION

DATE________________________________

NAME________________________________PARTNER'S NAME___________________________________

ADDRESS____

TELEPHONE NUMBER: DAY______________________________EVENING___________________________

D.O.B._____PARTNER'S D.O.B_______DURATION OF RELATIONSHIP___DURATION OF INFERTILITY___

INSURANCE COMPANY_____________________________INSURANCE ID#_________________________

NATURE OF PRESENT EMPLOYMENT (TITLE, BRIEF DESCRIPTION)______________________________

II. MEDICAL HISTORY **YES** **NO**

WEIGHT_____________HEIGHT____________BLOOD TYPE IF KNOWN________________

HAVE YOU LOST GREATER THAN 20 POUNDS OF WEIGHT IN THE LAST YEAR?............... ☐ ☐

DO YOU FOLLOW A PATRICULAR FOOD DIET OR HAVE ANY SPECIAL DIETARY HABITS?.. ☐ ☐

IF YES, SPECIFY:

____

LIST THE FORMS & FREQUENCY OF REGULAR VIGOROUS EXERCISE (SWIMMING, CYCLING, RUNNING & AGE YOU BEGAN: EXERCISE:__________HRS/WK_______AGE______
EXERCISE;________HRS/WK__________AGE______

HAVE YOU EVERY HAD ANY SURGERY?.. ☐ ☐

IF YES, SPECIFY DATE & TYPE ____

Do you have or have you ever had (check all that apply):

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Blood Transfusions
- ☐ Breast Milky Discharge
- ☐ Herpes
- ☐ Breast Tenderness
- ☐ Cancer? Specify_______________
- ☐ Chlamydia
- ☐ Chronic Bronchitis
- ☐ Chronic Headaches
- ☐ Colitis
- ☐ Color Blind
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Gallbladder problems
- ☐ Gonorrhea
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Scarlet Fever
- ☐ Hirsutism (Excess Hair Growth)
- ☐ High Blood Pressure
- ☐ Immunization:German Measles
- ☐ Kidney Infection
- ☐ Liver Infection
- ☐ Loss of Balance
- ☐ Measles: German
- ☐ Measles: Regular
- ☐ Neurological Problems
- ☐ Nongonococcal Urethritis
- ☐ Ovarian Cysts
- ☐ Parasitic Infection
- ☐ Pelvic Infection
- ☐ Pneumonia
- ☐ Poor Sense of Smell
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Syphilis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginitis (Trichomoniasis, yeast) # of episodes_______________
- ☐ Visual Disturbances
- ☐ Any Allergies____ _________________

YES NO

HAVE YOU EVER BEEN TREATED FOR CANCER?.. ☐ ☐
IF YES, EXPLAIN THERAPY____

HAVE YOU EVER RECEIVED X-RAYS TO THE PELVIC AREA FOR THERAPY OR DIAGNOSIS? ☐ ☐
IF YES, SPECIFY: ____

WITHIN THE LAST YEAR, HAVE YOU TAKEN ANY PRESCRIPTION MEDICATIONS?.............. ☐ ☐
IF YES, LIST ALL PRESCRIPTIONS AND PROBLEMS FOR WHICH YOU WERE TAKING THEM;

____

____

ARE YOU TAKING ANY OVER-THE- COUNTER MEDICATIONS ON A REGULAR BASIS?......... ☐ ☐
IF YES, LIST ALL MEDICATIONS AND DIAGNOSES:______________________________

____

DO YOU OR HAVE YOU EVER USED (CHECK ALL THAT APPLY):

☐ALCOHOL: HOW MANY GLASSES PER WK DO YOU USUALLY DRINK? WINE___BEER__COCKTAIL___

☐CIGARETTES -# PACKS PER DAY ______________

☐ILLICIT OR RECREATIONAL DRUGS (MARIJUANA, COCAINE, ETC.)

III. MENSTRUAL AND PREGNANCY HISTORY

AGE AT FIRST PERIOD?________________WHEN WAS YOUR LAST PERIOD?__________________

ARE YOUR PERIODS REGULAR?... ☐ ☐
IF YES WHAT ARE THE USUAL # OF DAYS BETWEEN PERIODS_____________________________

WHAT IS THE USUAL DRATION OF YOUR PERIOD?________________________
ARE CRAMPS PRESENT BEFORE, DURING OR AFTER YOUR PERIOD?__________________
ARE CRAMPS: ☐MILD ☐MODERATE ☐SEVERE

DO YOU HAVE TO TAKE PAIN MEDIATION FOR CRAMPS?... ☐ ☐
IF YES, SPECIFY MEDICATION:____

DO YOU BLEED OR SPOT BETWEEN PERIODS?.. ☐ ☐
HOW MANY PREGNANCIES (INCLUDING ABORTIONS) HAVE YOU HAD?_________________

	WHEN? (YEAR)	END IN ABORTION	END IN MISCAR.	ECTOPIC PREG.	INFERTILITY THERAPY REQUIRED TO CONCEIVE	HOW LONG TO CONCEIVE	BABY BORN ALIVE	DID YOU CONCIEVE WITH CURRENT PARTNER
1st pregnancy								
2nd pregnancy								
3rd pregnancy								
4th pregnancy								
5th pregnancy								
MORE THAN 5								

YES NO

WERE THERE ANY COMPLICATIONS DURING OR AFTER YOUR PREGNANCIES?................ ☐ ☐
IF YES EXPLAIN:____

DID YOUR MOTHER HAVE ANY DIFFCULTY WITH CONCEPTION OR PREGNANCY?............. ☐ ☐
IF YES EXPLAIN:____

HOW LONG HAVE YOU BEEN TRYING TO GET PREGNANT?_________________________
DID YOUR MOTHER TAKE DIETHYLSTILBESTROL (DES) WHEN SHE WAS PREGNANT WITH YOU?.. ☐ ☐

IV. CONTRACEPTIVE/SEXUAL HISTORY

WHAT FORM OF CONTRACEPTION DO YOU USE NOW OR HAVE YOU USED IN THE PAST? CHECK ALL THAT APPLY:
☐ PILLS NAME:______ ☐IUD NAME:____ ☐DIAPHRAGM ☐WITHDRAWL ☐FOAMS/JELLIES
☐CONDOM ☐RHYTHM ☐NONE OTHER________________________________

FOR EACH CONTRACEPTIVE METHOD USED SPECIFY LENGTH OF USE AND REASO N FOR DISCONTINUATION:

METHOD	LENGTH	COMPLICATIONS	REASON FOR DISCONTINUATION
____________	_____________	_____________________	______________________________________
____________	_____________	_____________________	______________________________________
____________	_____________	_____________________	______________________________________
____________	_____________	_____________________	______________________________________

IS SEXUAL INTERCOURSE PAINFUL? .... ☐ ☐

HOW MANY TIMES PER WEEK DO YOU AND YOUR PARTNER HAVE SEXUAL INTERCOURSE?_____

DO YOU USE LUBRICANTS FOR INTERCOURSE?... ☐ ☐
IF YES WHICH ONES____

DO YOU DOUCHE BEFORE OR AFTER INTERCOURSE.. ☐ ☐

V. FAMILY HISTORY

IS THERE A FAMILY HISTORY OF INFERTILITY?.. ☐ ☐
IF YES, WHO LIST ALL MEMBERS AND RELATIONSHIPS TO YOU______________________
____

IS THERE HISTORY OF HORMONAL DISORDERS IN YOUR FAMILY?.. ☐ ☐
IF YES WHAT TYPE:____
____

VI. HISTORY OF FERTILITY THERAPY

HAVE YOU BEEN TREATED FOR INFERTILITY BEFORE?.. ☐ ☐
IF YES, WHO WAS YOUR PHYSICIAN?____

WHAT CAUSE OF INFERTILITY WAS DIAGNOSED?___________________________________

WHAT DRUGS HAVE YOU TAKEN FOR INFERTILITY? CHECK ALL THAT APPLY:

- ☐ CLOMIP0HENE CITRATE(SEPOPHENE ®,COMID®)
- ☐ hCG (PROFASI ®, A.P.I. ®)
- ☐ hMG (PERGONAL®)
- ☐ BROMOCRIPTINE (PARLODEL®)
- ☐ ESTROGEN
- ☐ DANAZOL (DANOCRINE ®)
- ☐ PROGESTERONE
- ☐ UROFOLLITROPIN OR FSH (METRODIN®)
- ☐ PREDNISONE (OR CORTISONE-LIKE DRUGS)
- ☐ OTHER – SPECIFY________________________________
- ☐ ANTIBIOTICS
- ☐ NONE
- ☐ GnRH or LHRH (FACTREL ®)

WHICH OF THE FOLLOWING TESTS HAVE YOU HAD PERFORMED? CHECK ALL THAT APPLY AND THE RESULTS IF KNOWN:

TEST	WHEN?	RESULTS
☐ BBT	WHEN?____________	RESULTS________________
☐ POSTCOITAL TEST	WHEN?____________	RESULTS________________
☐ HORMONAL ASSAYS (FSH, LHJ, PROLACTIN,	WHEN?____________	RESULTS________________
ESTROGEN DHEA-S, TESTOSTERONE,	WHEN?____________	RESULTS________________
PROGESTERONE)	WHEN?____________	RESULTS________________
☐ ENDOMETRIAL BIOPSY	WHEN?____________	RESULTS________________
☐ HYSTEROSALPINGOGRAM	WHEN?____________	RESULTS________________
☐ ULTRASOUND	WHEN?____________	RESULTS________________
☐ ANTIBODIES	WHEN?____________	RESULTS________________
☐ LAPAROSCOPY, HYSTEROSCOPY	WHEN?____________	RESULTS________________
☐ MYCOPLASMA/CHALMYDIA CULTURES	WHEN?____________	RESULTS________________
☐ THYROID TESTS	WHEN?____________	RESULTS________________
☐ OTHER – SPECIFY ________________	WHEN?____________	RESULTS________________

	YES	NO
HAVE YOU EVER HAD SURGERY FOR TUBAL REVERSAL?..	☐	☐
IF YES SPECIFY DATES____		
HAVE YOU EVER HAD SURGERY FOR LYSIS OF ADHESIONS?..	☐	☐
HAVE YOU EVER HAD CERVICAL CONIZATON OF CAUTERY?..	☐	☐
HAVE YOU EVER HAD ANY OTHER SURGERY?...	☐	☐
IF YES SPECIFY:____		
HAVE YOU EVER UNDERGONE ARTIFICIAL INSEMINATION OR IN VITRO FERTILIZATION?.	☐	☐
IF YES, USING PARTNER OR DONOR SPERM?____		
IS YOUR PARTNER SEEING A DOCTOR FOR EVALUATION OF INFERTILITY?............................	☐	☐
IF YES, SPECIFY PHYSICIAN NAME AND LOCATION:___________________________________		
DOES THE DOCTOR FEEL THAT YOUR PARTNER HAS AN INFERTILITY PROBLEM?...............	☐	☐
IF YES, WHAT IS THE DIAGNOSIS AND HOW IS HE BEING TREATED?___________________		
HAS HE EVER FATHERED A CHILD WITH ANOTHER WOMAN?..	☐	☐
IF YES, WHEN____		

FOR PHYSICIAN USE ONLY

VII. PHYSICAL FINDINGS

VII. SURGERY

IX. OTHER COMMENTS

X. COURSE OF ACTION

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AUTHORIZATION TO RELEASE PERSONAL INFORMATION
HIPAA Compliant

I AUTHORIZE any physician, medical practitioner, hospital, clinic, health care facility, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, employer having information available as diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me to provide to New Life Agency, Inc. or to any agency authorized by New Life Agency, Inc. to collect any and all such information by means of U.S. Post , fax or e-mail.

I AUTHORIZE New Life Agency, Inc. to communicate with me or my representative via mail, phone, fax or electronic mail regarding quotations, underwriting, claims, coverage administration, or additional coverage's from New Life agency, Inc..

I UNDERSTAND the purpose of this Authorization is to allow New Life Agency, Inc. to determine eligibility and claim payment for life or health insurance or claim for benefits under a life or health policy. Any information obtained will not be released by New Life Agency, Inc. to any person or organization EXCEPT to those persons or organizations needing such information in performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I UNDERSTAND that I may revoke this Authorization, except to the extent that New Life Agency, Inc. has acted in reliance upon this Authorization. My revocation must be submitted in writing to New Life Agency, Inc. Any such revocation may also have an impact upon my Underwriting or claims processing.

I UNDERSTAND that I can obtain a complete copy of New Life Agency, Inc. Privacy Policy either on New Life Agency, Inc. website or by contacting them directly and asking for a copy.

I AGREE that a photostatic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two years from the date shown below.

Signed this day_______ of_______ 20_______

____
Signature of proposed Female Program Participant

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Complete:
1. To complete the application on line, tab to each area and type it in. To place checks in the boxes, you can either use the space bar or your mouse. Print, sign and date the application and fax it back with this completed cover sheet.

or

2. Print the application; complete each area by hand or typewriter. Print, sign and date it and fax it back with this completed cover sheet.

Submit:
1. Make sure all information below is completed then fax or mail both pages to New Life Agency, Inc.
41-750 Rancho Las Palmas Drive • Suite N-3 • Rancho Mirage, CA 92270
Tel (877) 952-5433(LIFE) • Fax (877) 952-5589

TO:	**Policy Coordinator**	**FAX: (877)952-5589**
	E-Mail: sales@newlifeagency.com	**PHONE: 877-952-5433 (LIFE)**
		E-Mail: sales@newlifeagency.com

COMMENTS:

Thank you

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