CLEAVER DERMATOLOGY · PO BOX 7545 · 1316 COUNTRY CLUB DRIVE, KIRKSVILLE, MO 63501 · 660-627-7546

CLEAVER DERMATOLOGY PATIENT REGISTRATION FORM TODAY'S DATE: _____

Name_____ Date of Birth_____
First MI Last

Do you have a DPOA who currently makes your medical decisions for you? (Circle one that applies) ☐ Yes or ☐ NO

Social Security Number: _____ Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Email: _____

Is it ok to leave a detailed message ☐ Yes ☐ No ☐ N/A

Primary Doctor: _____ Primary Doctor's Phone #: (_____)_____-_____

Referred by: ☐ Doctor _____ ☐Family ☐Friend ☐Internet ☐Phone Book ☐Newspaper ☐Ad

Name of Pharmacy you prefer: _____ Preferred Language: _____

Race (circle one): ☐African American ☐American Indian or Alaskan Native ☐Native Hawaiian or other Pacific Islander

☐Asian ☐White ☐Other: _____

Ethnic Group (circle one): ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown ☐Unspecified

Patient Occupation: _____ Employer: _____
Name Phone#

Employer Address: _____
Street City State Zip

Student: ☐ Full-Time or ☐ Part-Time Name of School: _____

EMERGENCY CONTACT OR PARENT/LEGAL GUARDIAN (IF MINOR)

Name: _____ Phone #: _____

Relationship to Patient: _____

Parent or Legal Guardian Financially Responsible for Minor: _____

Address: _____ Date of Birth: _____

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Patient Name: _____

Date of Birth: _____

Please list the name(s) and Phone #(s) of the person(s) with whom you give us permission to discuss your medical condition as well as their relationship to you. If you are the parent or guardian of the patient, please include yourself in this list.
(I.E. friend, neighbor, child, etc.)

Name:	Relationship:	Phone #:

☐ Check here if you do not wish for us to discuss your condition with anyone other than yourself.

Patient Signature: _____

Date: _____

*** You may change any of this information at any time. Please check with a receptionist or nurse and they will supply a new form for you. Thank you.**

Cleaver Dermatology History and Intake Form

Name: _____

Date of Birth: _____

Past Medical History: (Check any of the following conditions that you currently have or have had)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blindness
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes (Type 1 or Type 2)
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hearing Loss
- ☐ Hepatitis (A, B or C)
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hypothyroidism (Low)
- ☐ Hyperthyroidism (High)
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Stroke
- ☐ Other_____
- ☐ Other_____

Past Surgical History: (Please circle all that apply)

- ☐ Basal Cell Carcinoma Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy or Lumpectomy (Right, Left, or Both)
- ☐ Breast Reduction or Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis or IBS
- ☐ Colostomy
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Heart Stents
- ☐ Heart Transplant
- ☐ Heart Valve Replacement (biological or mechanical)
- ☐ Joint Replacement within last 2 years_____(location)
- ☐ Kidney Removed (Right or Left)
- ☐ Kidney Transplant (Right or Left)
- ☐ Pacemaker/Defibrillator Implant
- ☐ Radiation Treatment :_____(reason)
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy :_____(reason)
- ☐ Ovaries Removed :_____(reason)
- ☐ Other_____

Skin Disease History: (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin/Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Seasonal Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other_____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF?_____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)?_____

Medications: (Please list all current medications including over-the-counter products and herbals)

_____

_____

_____

_____

Allergies: (Please list all drug and environmental allergies)

_____

_____

_____

Social History: (Please check all that apply)

☐ Currently smoke	☐ Have smoked in the past	☐ Have never smoked	☐ Drug Use
☐ Chew tobacco	☐ Have chewed tobacco in past	☐ Have never chewed	☐ Other_____
☐ No alcohol intake	☐ Less than 1 drink per day	☐ 1-2 drinks per day	☐ +3 drinks daily

Family History: (Please list major health problems with parents, siblings, or children)

_____

_____

Please check ALL that apply to YOU:

☐ Yes	or	☐ No	Do you or did you have Hepatitis A, B or C? (Circle one that applies)
☐ Yes	or	☐ No	Do you have HIV or AIDS?
☐ Yes	or	☐ No	Does your insurance dictate labs be sent to Quest or LabCorp?
☐ Yes	or	☐ No	Do you have a metal implant and cannot have an MRI?
☐ Yes	or	☐ No	Pacemaker of Defibrillator Implant? (Circle one that applies)
☐ Yes	or	☐ No	Have you had an organ transplant?
☐ Yes	or	☐ No	Artificial joint replacement within the last six months?
☐ Yes	or	☐ No	Artificial heart valve? (Includes mechanical or biological)
☐ Yes	or	☐ No	Rapid heartbeat with epinephrine (Often mixed with numbing medicine)?
☐ Yes	or	☐ No	Mitral valve prolapse or heart murmur?
☐ Yes	or	☐ No	Currently on blood thinners including regular use of aspirin or NSAID's?
☐ Yes	or	☐ No	Antibiotics needed prior to dental work or other surgical procedures?
☐ Yes	or	☐ No	Allergy to latex? (Mild or Severe)
☐ Yes	or	☐ No	Allergy to adhesives such as Band-Aids or tapes?
☐ Yes	or	☐ No	Allergy to topical antibiotic ointments?
☐ Yes	or	☐ No	Allergy to Novocaine?
☐ Yes	or	☐ No	Allergy to Betadine or Iodine?
☐ Yes	or	☐ No	Allergy to Lidocaine?
☐ Yes	or	☐ No	Allergy to IV dye/Contrast Solution used in diagnostic procedures?
☐ Yes	or	☐ No	Allergy to Bactroban or mupirocin antibiotic ointment?
☐ Yes	or	☐ No	Currently pregnant or sexually active without use of prevention? (Circle one that applies)
☐ Yes	or	☐ No	History of fainting or getting lightheaded during shots or procedures?
☐ Yes	or	☐ No	Difficulty getting numb with local anesthetics such as at the dentist?
☐ Yes	or	☐ No	Yeast infections with oral antibiotics?
☐ Yes	or	☐ No	Upset stomach with oral antibiotics?
☐ Yes	or	☐ No	Any history of seizures?

Cleaver Dermatology and Skin Spa

Payment Policy Notification

Thank you for choosing Cleaver Dermatology for your skin care specialty needs. We are committed to providing you with high quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please review, ask any questions you may have, and sign in the space provided. A copy will be placed in your patient file and will be provided to you upon request.

- **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

- **Co-payments and deductibles**. All co-payments must be paid at the time of service. When a surgery or other major procedure is scheduled, we will contact your insurance company and an estimate will be prepared for you. Payments must be made the day of service based on your plan. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraudulent. Therefore, payment at time of service is mandatory. If there is a balance remaining on your account, you will be required to pay the balance prior to being seen again.

- **Non-covered and/or cosmetic services**. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

- **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

- **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

- **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

- **Nonpayment.** Accounts should be paid upon receipt of bill. If payment has not been made within 90 days of receiving the bill, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.

- **Travel Clinics**-It is very important to us that we serve patients in outlying communities. As such, our schedules are very heavy on these days and slots are valuable. If you miss any two

appointments at one of our travel clinics, you will need to schedule at the Kirksville location only.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Patient Print Name Birthdate

_____ _____

Signature of Patient or Responsible Party Date

Consent to Treat, Authorization to File Insurance, Privacy Policy

Consent for Minor Surgery, Biopsy & Cryosurgery
During your visit, the dermatologist may need to perform cryosurgery or a skin biopsy to treat or evaluate your skin condition. Please review and sign the consent form below. You will be given ample time to discuss the procedure if the doctor determines cryosurgery or a biopsy is necessary. This will serve as a standing consent for this and any and all future treatments, however verbal consent will always be obtained prior to any treatment.

PURPOSE:
A biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.

Cryosurgery is the use of liquid nitrogen to freeze the skin lesions that respond well to sub-zero temperatures. The process freezes potential skin cancers known as actinic keratosis or solar keratosis. The treatment is also used to freeze the virus infections that cause many common warts.

PROPOSED TREATMENT:
I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain risks including bleeding, post-operative pain, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician (such as the degree of sun damage or patient compliance with post-operative instructions) affect the ultimate healing.

A pathologist will examine the tissue obtained in this biopsy procedure. I understand I may receive a separate bill from the pathologist or laboratory for this microscopic examination.

Complications of applying liquid nitrogen to the skin may include:

- Irritation
- Redness
- Temporary discomfort
- Blistering
- Infection
- Permanent loss of pigmentation

After the lesion has been treated, most patients develop a blister or scab that lasts for 1-2 weeks.

OTHER ACKNOWLEDGEMENT DISCLOSURE:
I am able to read and understand English. I understand that I will have the opportunity to discuss my procedure with the physician or other professional who is to perform the procedure and have all of my questions answered to my satisfaction.

PHOTOGRAPHIC CONSENT:
I AUTHORIZED AND CONSENT TO THE TAKING OF A SERIES OF PHOTOGRAPHS OF THE SURGICAL AREAS FOR THE USE OF DR. CLEAVERFOR DOCUMENTATION OR EDUCATIONAL PURPOSES.

Insurance and Privacy Policy Consent
I hereby acknowledge that I have been presented with a copy of Cleaver Dermatology's Notice of Privacy Practices.

This office is required to keep your signature on file authorizing us to file claims for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any health insurance carrier that I have a policy with any information needed for this claim or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

If you have a supplement policy or a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a signature on file.

I authorize Cleaver Dermatology to file my insurance. I acknowledge that I have been offered or received a copy of the privacy policy. I give my consent to be treated by the physician.

I agree to not photograph or record any part of my procedure during my visit today. This includes by camera, tablet, or cellular device.

_____

Patient Name: Patient Date of Birth:

_____

Patient / Agent / Guardian Signature Today's Date: