

MEDICARE PATIENT REGISTRATION

Name: \_\_\_\_\_ JR. \_\_\_\_\_ SR. \_\_\_\_\_  
First Middle Last

Nickname/preferred name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Social Security #: \_\_\_\_\_ Sex:  Male or  Female

Address: \_\_\_\_\_  
Street # Street Name Apt #

City State Zip

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(if applicable) Month/day/year

Spouse's Social Security #: \_\_\_\_\_ (required by some insurance policies)

Who Referred You: \_\_\_\_\_ (name of Dr, friend, etc.)

Employer Name and Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_  
Name Address Phone

Please answer the questions below by placing a check in the appropriate column:

Yes No

\_\_\_ \_\_\_ Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?

\_\_\_ \_\_\_ Are you covered by a HMO/PPO which makes Medicare secondary?

\_\_\_ \_\_\_ Is this illness covered by the VA Veteran's Administration?

\_\_\_ \_\_\_ Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?

\_\_\_ \_\_\_ Is this illness due to an automobile accident?

\_\_\_ \_\_\_ Is this illness due to an injury at work?

\_\_\_ \_\_\_ Are you receiving Medicaid?

- Turn Over-

This office is required to keep your signature on file authorizing us to file claims to Medicare 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 any information needed for this 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 assignment of benefits apply.*

\_\_\_\_\_  
Signature as it appears on Medicare Card

\_\_\_\_\_  
Date

If you have a supplemental policy or a MEDIGAP policy to which your Medicare Carrier automatically “crosses over”, we are required to keep a separate signature on file:

\_\_\_\_\_  
NAME OF SUPPLEMENT/ SECONDARY INSURANCE/ MEDIGAP CARRIER

*I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP Carrier any information needed to determine these benefits or the benefits payable for related services.*

\_\_\_\_\_  
Signature as it appears on Supplement/ Medigap Card

\_\_\_\_\_  
Date

- You will be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by Medicare.

EMERGENCY CONTACT NAME: \_\_\_\_\_

RELATIONSHIP TO PT: \_\_\_\_\_  
(i.e. friend, child, neighbor, etc.)

EMERGENCY CONTACT PHONE #: \_\_\_\_\_

Please present your insurance cards and your photo ID to the receptionist. The receptionist will make a copy and return them to you promptly.

Thank you for choosing this office to assist in caring for your skin.

## Dermatology Medical History

Patient: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  YES  NO If YES, list: \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine)?  YES  NO Any bad reactions?  YES  NO

List any medications you are currently taking (Prescriptions, over-the-counter meds, Aspirin, vitamins, herbs):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now or have you ever had diseases or conditions of: (Please  $\checkmark$  YES or NO)

<i>Lungs:</i>	<i>YES</i>	<i>NO</i>	<i>Other Systemic:</i>	<i>YES</i>	<i>NO</i>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
			Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/Burning	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach Absorptive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Nausea, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
			when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Yeast Infection when taking	<input type="checkbox"/>	<input type="checkbox"/>
			antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
			Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or	<input type="checkbox"/>	<input type="checkbox"/>
			Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any condition requiring antibiotics before dental procedures?  YES  NO

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

**Skin:** Have you ever had skin cancer?  YES  NO  
 Has anyone in your family had skin cancer?  YES  NO If YES, who? \_\_\_\_\_ What kind? \_\_\_\_\_  
 Do you have a history of any specific skin diseases?  YES  NO  
 Do you have problems w/ healing or develop keloids (scars)?  YES  NO  
 Do you bleed easily?  YES  NO  
 Do you develop skin rashes in reaction to:  Medications  Food  Environment  Bandages  Topical Neosporin  
 Other \_\_\_\_\_

### Social History:

Do you drink alcohol?  YES  NO If YES, \_\_\_\_\_ drinks/day  
 Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_  
 Do you use tobacco?  YES  NO If YES, how much? \_\_\_\_\_  
 Have you ever been exposed to HIV (AIDS)?  YES  NO  
 (Women) Are you pregnant?  YES  NO Due Date: \_\_\_/\_\_\_/\_\_\_  
 What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by:  Patient \_\_\_\_\_  Other \_\_\_\_\_  
 Signature of Patient \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 Reviewed by \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Dr. Lloyd J. Cleaver  
700 West Jefferson  
Kirksville, MO 63501  
(660) 626-2191

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

- |  |     |    |
|--|-----|----|
| 1. Have you ever had TB (tuberculosis)?  | Yes | No |
| 2. Have you been living with anyone in the past 2 years who have been diagnosed with TB? | Yes | No |
| 3. Have you had a persistent cough and fever for more than 2 weeks?                      | Yes | No |
| 4. Have you had a persistent cough and night sweats for more than 2 weeks?               | Yes | No |
| 5. Have you had a persistent cough or loss of appetite for more than 2 weeks?            | Yes | No |
| 6. Have you been coughing up or spitting up bloody saliva?                               | Yes | No |

Reviewed by \_\_\_\_\_  
(Nurse or Dr. signature)

Date \_\_\_\_\_

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, Dr. Lloyd J. Cleaver may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Dr. Lloyd J. Cleaver's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Lloyd J. Cleaver reserves the right to revise this Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Lloyd J. Cleaver's Privacy Officer at 700 West Jefferson, Kirksville, MO 63501.

With my consent Dr. Lloyd J. Cleaver may call my home or other designated location and leave a message on a voice mail or in person in reference to any items that assist the practice in carrying out TPO. Such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dr. Lloyd J. Cleaver may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

By signing this form, I am consenting to Dr. Lloyd J. Cleaver's use and disclosure of my Personal Health Information to carry out treatment, payment, and healthcare operations. I have also received and reviewed the Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has already made a disclosure in reliance upon my prior consent. If I don not sign this consent, Dr. Lloyd J. Cleaver may decline to provide Treatment to me.

I hereby acknowledge that I have been presented with a copy of Dr. Lloyd J. Cleaver's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent or Legal Guardian

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. (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.

May we leave a message on your answering machine? \_\_\_\_ Yes \_\_\_\_ No

May we call you at work? \_\_\_\_ Yes \_\_\_\_ No

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.

**Notice of Privacy Practices**  
**Dr. Lloyd J. Cleaver, DO, LLC**

*To our patients:* This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

**Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

**Your rights regarding your health information.**

1. **Communications.** You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operation. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Connie Jones Privacy Officer for Dr. Lloyd J. Cleaver, DO, LLC, 700 West Jefferson, Kirksville, MO 63501.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to Connie Jones Privacy Officer for Dr. Lloyd J. Cleaver, DO, LLC, 700 West Jefferson, Kirksville, MO 63501. You must provide us with a reason that supports your request for amendment.
5. Right to obtain a copy of this notice. You are entitled to receive a copy of this Notice Of Privacy Practices. You may ask us to give a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Connie Jones Privacy Officer for Dr. Lloyd J. Cleaver, DO, LLC, 700 West Jefferson, Kirksville, MO 63501. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Connie Jones Privacy Officer for Dr. Lloyd J. Cleaver, DO, LLC, 700 West Jefferson, Kirksville, MO 63501.