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

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

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

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

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: _____

PLEASE PRESENT INSURANCE CARDS SO THAT COPIED MAY BE MADE

_____ _____
Primary Insurance Secondary Insurance

_____ _____
Name of Insured (policyholder) Relation Name of Insured (policyholder) Relation

Phone #: _____ Phone #: _____

DOB: _____ SSN: _____ DOB: _____ SSN: _____

WE REQUIRE ½ OF PAYMENT FOR ALL COSMETIC PROCEDURES AT THE TIME THEY ARE SCHEDULED. 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.

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

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 _____ N/A

May we call you at work? _____ Yes _____ No _____ N/A

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: (Circle any of the following conditions that you currently have or have had)

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

Past Surgical History: (Please circle all that apply)

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

Other_____

Skin Disease History: (Please circle all that apply)

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

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 circle 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 circle ALL that apply to YOU:

Yes	or	No	Do you have a DPOA or Guardian who currently makes your medical decisions for you? (Circle one that applies)
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	Insurance dictates that labs be sent to an outside lab such as Quest or Labcore?
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 Mmupirocin 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?