

MEDICARE PATIENT REGISTRATION

Name: _____ JR. _____ SR. _____
First Middle Last

Nickname/preferred name: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Social Security #: _____

Address: _____
Street # Street Name Apt #

City State Zip

Home Phone: _____ Emergency contact: _____
(name and phone #)

Spouse: _____ Spouse's Date of Birth: _____ / _____ / _____
Month/ day / year

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 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 Medigap Card/ Supplement 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.

Do we have your permission to:

Leave a message on your answering machine? ____ Yes ____ No

May we call you at work? ____ Yes ____ No

* Discuss your medical condition with any member of your household/family or any other person(s) you list? ____ Yes ____ No

If yes, please name person(s) and their relationship to you. (i.e. friend, neighbor, child, etc.)
*See attached form

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)

Lungs:	YES	NO	Other Systemic:	YES	NO
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 when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Yeast Infection when taking 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 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

Signature of Patient

Date

Other _____

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 do 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) 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.)

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.