



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: \_\_\_\_\_ Birth Sex (please circle one): Male Female  
 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 Ad  
 Preferred Pharmacy: \_\_\_\_\_ Preferred Language: \_\_\_\_\_  
 Race (**circle one**): African American Native American 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: \_\_\_\_\_

CLEAVER DERMATOLOGY PATIENT REGISTRATION FORM TODAY'S DATE: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**  
 Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Parent or Legal Guardian Financially Responsible for Minor: \_\_\_\_\_  
 Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_



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.

Signature of Patient or Responsible Party: \_\_\_\_\_

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                                |  |
| Breast Implants                                 | Pacemaker/Defibrillator Implant                    |
| Colectomy: Colon Cancer Resection               | Radiation Treatment : _____ (reason)               |
| Colectomy: Diverticulitis or IBS                | Spleen Removed                                     |
| Colonoscopy                                     |  |
| Colostomy/Ostomy                                | 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

**Vaccine History:** If you are 66 or older, have you received your pneumonia vaccine? \_\_\_\_\_

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

---

---

**Please circle 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 or 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 trying to conceive?
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. At this point, the account must be paid in full or an ACH payment plan must be put in place. 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.
- **Payment plans.** A billing specialist will work with you to implement the ACH payment plan when warranted. Balances of \$1000 or less must be paid in no more than 12 months. Balance over \$1000 may be paid over 24 months.
- **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 AUTHORIZE 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.*

---

Print Patient Name:

Patient Date of Birth:

---

Signature of Patient or Responsible Party      Today's Date: