

Cleveland Dermatology
Mercy Plaza-Suite 252
1225 S. Gear Ave.
West Burlington, IA 52655
Phone: 319-752-1805
Toll Free: 888-752-3686

WELCOME TO OUR OFFICE! Thank you for your interest in making an appointment with us. Please fill out the following registration information.

Your appointment is scheduled for: _____ at _____ am
pm

At the following location:

With Provider:

West Burlington
Mercy Plaza Suite 252
1225 S. Gear Ave.

Mark Cleveland, M.D., Ph.D.
 Amy John, P.A.-C
 Carol Menke, P.A.-C.

Fort Madison
Specialty Clinic Suite 123
5409 Ave. O

Mt. Pleasant
Specialty Clinic Suite 1
407 South White

**PLEASE BRING YOUR CURRENT
INSURANCE CARD (S) AND
COMPLETED PAPERWORK
WITH YOU TO YOUR APPOINTMENT.**

DO NOT MAIL BACK

-Please turn over-

CLEVELAND DERMATOLOGY-NEW/UPDATED PATIENT INFORMATION

PATIENT INFORMATION

NAME: _____ MAIDEN NAME: _____
Last, First, Middle

DATE OF BIRTH: _____ AGE: _____ SEX: _____

ADDRESS: _____
Street Address City, State, Zip Code

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____ EMPLOYER: _____
CIRCLE MARITAL STATUS: Single Married Separated Divorced Widowed

RESPONSIBLE PARTY/BILLING INFORMATION

NAME: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ SSN: _____ DATE OF BIRTH: _____

ADDRESS: _____
Street Address City, State, Zip Code

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

INSURANCE INFORMATION (If you have an insurance card, please give it to the receptionist for copying purposes)

PRIMARY POLICYHOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER'S DOB: _____ SSN: _____ EMPLOYER: _____

INSURANCE CO. NAME: _____ ID #: _____

GROUP #: _____ INSURANCE PHONE #: _____

CLAIMS ADDRESS: _____

2ND POLICYHOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER'S DOB: _____ SSN: _____ EMPLOYER: _____

INSURANCE CO. NAME: _____ ID #: _____

GROUP #: _____ INSURANCE PHONE #: _____

CLAIMS ADDRESS: _____

MISCELLANEOUS INFORMATION

In Case of Emergency Notify: _____ Relationship to Patient: _____
Phone#: _____

Results of any lab work, pathology reports, or any other diagnostic test can be shared with the following:
___ Patient ___ Spouse ___ Parent ___ Other _____

POWER OF ATTORNEY (If applicable): _____
Contact Information: _____

REFERRING PHYSICIAN: _____

I authorize the release of any medical or other information necessary to process claims. I also authorize payment of medical benefits to the physician or practice. I understand that I am responsible for any balance remaining after insurance payment. I understand that payment is expected at time of service if I do not have insurance.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____ DATE: _____

CLEVELAND DERMATOLOGY
MARK G. CLEVELAND, M.D., PH.D

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

With my consent Cleveland Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **CLEVELAND DERMATOLOGY'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. Cleveland Dermatology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Cleveland Dermatology Privacy Officer at 1223 S. Gear Ave., Suite 309. West Burlington, IA 52655
With my consent, Cleveland Dermatology may call my home or other designated location and leave a message on 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, Cleveland Dermatology 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.

With my consent, Cleveland Dermatology may e-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. I have the right to request that Cleveland Dermatology restrict how it uses or discloses my PHI to carry out TPO.

HOWEVER, THE PRACTICE IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF IT DOES, IT IS BOUND BY THIS AGREEMENT.

By signing this form, I am consenting to Cleveland Dermatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Cleveland Dermatology may decline to provide treatment to me.

Print Name of Patient

Signature of Patient or Legal Guardian

Print Date

Print Name of Signer if not patient

MEDICAL HISTORY FORM

Name: _____ Date: _____

Occupation: _____ Birth date/Age: _____

Describe the main reason for your visit/referral: _____

Have you been treated for other skin problems in the past? (type, year, treatment) _____

Have you or a family member ever been treated for skin cancer in the past? yes no (person, type, location, year, treatment) _____

How would you describe your skin? Tan only Tan and Burn Burn only

Have you been previously diagnosed or treated for any of the following?

<u>Condition</u>	<u>Yes</u>	<u>No</u>	<u>Condition</u>	<u>Yes</u>	<u>No</u>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal colitis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Angina or Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Aids/HIV/hepatitis exposure	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/emotional illness	<input type="checkbox"/>	<input type="checkbox"/>
Breathing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores or fever blisters	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Excessive scarring/keloids	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Problems with local anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Problems with healing	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatments	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ultraviolet light therapy	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Other illnesses:	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
disease/hepatitis/jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Do you take antibiotics before you go to the Dentist? yes no (if yes, why?) _____

Do you take blood thinners yes no (please list) _____

Provide information on any condition for which you responded "yes" to above: _____

List previous surgery/hospitalizations including year and reason: _____

Do you smoke? yes no How much? _____ How many years? _____
Do you drink alcohol? yes no How much? _____
Do you have pets? yes no What kind? _____
Are you allergic to any medication, food, or anesthetic (numbing medicine)? yes no _____

List all medications that you are currently taking. Include over-the-counter medications and medications that you take only occasionally:

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there any other information that the physician should be aware of? _____

As a service to our new patients, we offer a complete skin exam at no additional charge, unless further procedure is indicated. This allows us to feel confident that we are not missing anything that may be important to your treatment. If you choose to have a full skin exam you will be provided a gown and asked to remove all clothing except your undergarments. Would you like a complete skin exam during your visit? yes no

Patient Signature: _____ Date: _____

Read and reviewed with the patient. _____ Date: _____
Mark G. Cleveland, M.D., Ph.D./ Amy J. John, PA-C
Carol A. Menke PA-C