

Riley Perry Lloyd, MD, FACOG

DATE: _____

HOW WOULD YOU LIKE TO BE ADDRESSED BY THE STAFF: _____

NAME: _____ / _____ / _____
FIRST INITIAL LAST D.O.B.

STREET: _____ # _____

CITY: _____ STATE: _____ ZIP CODE: _____

(_____) _____
PATIENT Cell Phone number W/ AREA CODE

(_____) _____
WORK TELEPHONE W/ AREA CODE

EMAIL: _____ @ _____

OCCUPATION

EMPLOYER

Insured's Name (If not the patient)

Insured's Employer

_____/_____/_____
Insured's DOB

PLEASE CIRCLE: SINGLE LIFE PARTNER MARRIED SEPARATED DIVORCED WIDOW

EMERGENCY CONTACT NAME

RELATIONSHIP TO PATIENT

(_____) _____
AREA CODE & TELEPHONE OF EMERGENCY CONTACT

HOW DID YOU HEAR ABOUT US? REFERRED BY: _____ GOOGLE
 FACEBOOK/SOCIAL MEDIA FRIEND/FAMILY OTHER: _____

4905 Old Orchard Center, Suite #330
Skokie, IL 60077

Be Well Family Care
12430 N. Clark St,
Carmel, IN 46032

Phone: 847.763.7100 | Fax: 847.763.7102

Patient Consent to Leave a Detailed Messages/Information

Dear Patient:

Dr. Lloyd requires our staff to obtain prior authorization to leave detailed voicemail/messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient’s confidentiality. If we do not have a signed consent form on file, the staff may only leave their name and a phone number in a message asking you to call them back.

By completing this consent below, you hereby authorize the staff to call and leave their name, the doctor’s name, and any additional information *including test results* on a voicemail/answering machine and/or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I _____ (*print your name*) give my consent to Dr. Lloyd and/or his staff to leave voicemail/messages regarding appointments, treatments, test results, or any other necessary information at the numbers listed below.

Cell phone voicemail (_____) _____ - _____

Home voicemail (_____) _____ - _____

Patient Signature

____/____/_____
Date

I _____ (*print your name*) **DO NOT GIVE MY CONSENT TO ANY MESSAGES BEING LEFT ON A VOICEMAIL OR ANSWERING MACHINE OTHER THAN THE CALLER’S NAME AND PHONE NUMBER.**

Patient Signature

____/____/_____
Date

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Financial Policy

Thank you for choosing Dr. Riley Perry Lloyd as your healthcare provider. We are honored by your choice and committed to providing you with quality care.

The responsibility for payment for all treatments is always the responsibility of the patient (or the parent/guardian of the patient if the patient is a minor). Patients with an HMO or PPO health plan are responsible for copay, deductibles, co-insurance and all procedures not covered by their health plan. It is the patient's responsibility to provide the office with accurate health plan information.

Payment is due at the time of service; we accept Cash, Visa, MasterCard, and Discover, we also accept personal checks. Patients who have a health plan can elect to use their coverage as part of their payment and we shall file their claims directly to the insurance company. However, co-payments are due at the time of service.

If there is any amount due after the insurance company reimbursement, the balance is due within 30 days. If you have financial hardship you must contact the office in writing so that special payment arrangements can be made.

I hereby authorize direct payment of surgical/medical benefits to Dr. Riley Perry Lloyd for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize Dr. Riley Perry Lloyd to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I certify the information given by me in applying for this payment is correct. I authorize the release of all medical records on request. I request that payment authorized benefits be made on my behalf.

Patient Name (please print)

_____/_____/_____
Date

Patient Signature

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Patient Consent For Use & Disclosure of Protected Health Information (PHI)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Riley Perry Lloyd, MD, has the right to revise his Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to 4905 Old Orchard Center, Suite 303, Skokie, IL 60077.

With my consent Riley Perry Lloyd, MD, may use and disclose **Protected Health Information (PHI)** about me to carry out **Treatment, Payment and Healthcare Operations (TPO)**. Please refer to Riley Perry Lloyd, MD, Notice of Privacy Practices for a more complete description of such disclosures.

With my consent Riley Perry Lloyd, MD, and his staff may call my phone number/s listed on my registration sheet and leave a message on my voicemail, or in person, in reference to any items that assist the practice in carrying out **TPO**. These messages may include appointment reminders, pre-registration, insurance items and/or any calls pertaining to my medical care.

With my consent, Riley Perry Lloyd, MD, may mail to my home, or another designated location listed on my registration form, any items that assist the practice in carrying out **TPO**. However, he is not required to agree to my requested restrictions, but if he does, it is bound by this agreement.

By signing this form, I am consenting Riley Perry Lloyd, MD, the use and disclosure of my **PHI** to carry out **TPO**.

I may revoke my consent in writing except to the extent that he has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Riley Perry Lloyd, MD, may decline to provide treatment to me.

Patient Name (please print)

____/____/_____
Date

Patient Signature

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PATIENT REGISTRATION FORM: FEMALE

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Primary Care Physician Name: _____

Physician Phone Number: _____ **Date of last visit:** _____

1. What is the reason for your visit today? If it is a problem, please describe the symptoms and be specific: _____

2. Date of last pap smear: _____ Results: _____

If abnormal, list treatment: _____

3. **Date of last mammogram:** _____ **Results:** _____

If abnormal, list treatment: _____

4. Do you have or have you ever had breast cancer? YES NO

If yes, please describe treatment: _____

5. Date of last menstrual period: _____

6. Are your menstrual periods regular? YES NO

If no, please explain _____

7. If you no longer have periods, please check the reason:

Hysterectomy Ablation Menopause & Age of Menopause: _____

8. Have you had any abnormal bleeding in the past year? YES NO

If yes, please describe: _____

9. Please list any medications you are currently taking and dosage amounts: _____

10. **Do you have any drug allergies?** YES NO

If yes, please list drugs you are allergic to: _____

11. Do you have any thyroid problems? YES NO

If yes, which type? Low Function Overactive Goiter Hashimoto

12. Are you using any form of Hormone Therapy? YES NO

If yes, please describe _____

Symptom Checklist

Please indicate how often you have the following

	Frequently	Rarely	Never		Frequently	Rarely	Never
Night sweats				Migraines			
Hot flashes/hot flushes				Depression			
Pain with intercourse				Anxiety			
Vaginal dryness				Decrease in sexual desire			
Sleeping problems				Decrease in energy level			
Urine leaks when you cough or sneeze				Loss of memory			
Difficulty concentrating or memory loss				Foggy thinking			
Mood swings				Muscle and/or joint pain			

Please describe the way in which these issues have been dealt with: _____

OB History

1. How many times have you been pregnant? _____
2. How many miscarriages have you had? _____
3. How many abortions have you had? _____
4. Have you had any Tubal/Ectopic pregnancies? _____
5. How many vaginal deliveries have you had? _____
6. How many Cesarean Sections have you had? _____
7. Have you had any premature deliveries? _____
8. Have you had any babies weighing less than 5lbs 8oz at birth? _____

OB History (continued)

9. How many full term deliveries? _____
10. Have you had any twin births? _____
11. Did you have any complications with your pregnancies? YES NO
 If YES, please list: _____

-

GYN History

1. Are you sexually active? YES NO
2. Have you been sexually active? YES NO
3. Do you have pain with intercourse? YES NO
4. What type of contraception are you currently using? (Please select all that apply):
 Pills IUD Foam Condoms
 Tubal Ligation Vasectomy Diaphragm Withdrawal
 Implants Depo Provera
 Other: _____
5. What type of contraception have you used in the past (Please select all that apply):
 Pills IUD Foam Condoms
 Tubal Ligation Vasectomy Diaphragm Withdrawal
 Implants Depo Provera
 Other: _____
6. Are you having any problems with your current method of birth control? YES NO
7. Have you ever had a vaginal, cervical and/or tubal infection? YES NO
 If yes, please select below all that apply:
 Gonorrhea Yeast Herpes Warts
 Gardnerella Syphilis Condyloma Bacterial Vaginitis
 PID Chlamydia Other: _____
8. Have you ever had **cervical cancer**? YES NO
 If yes, how was it treated? _____
9. Have you ever had **uterine cancer**? YES NO
 If yes, how was it treated? _____
10. Do you have any breast lumps, tenderness or discharge? YES NO
11. Do you do self-breast exams? YES NO

GYN History (continued)

12. Do you have PMS symptoms? YES NO

If yes, describe how are you currently treating symptoms: _____

13. Do you have any uterine abnormality? YES NO

14. Do you have a history of infertility? YES NO

15. Do you have a history of DES exposure? YES NO

16. Do you have fibroids of the uterus? YES NO

Medical History

1. Do you have **diabetes**? YES NO

2. Do you have or have you ever had **hypertension**? YES NO

3. Do you have **heart disease**? YES NO

4. Have you ever had a **stroke**? YES NO

5. Do you have a **heart murmur**? YES NO

6. Do you have or have you ever had **kidney disease**? YES NO

7. Have you ever been treated for a **psychiatric disorder**? YES NO

If yes, please name the disorder: _____

8. Have you ever had **rheumatic fever**? YES NO

9. Do you have **mitral valve prolapse**? YES NO

10. Have you ever had a **urinary tract infection**? YES NO

11. Have you ever had **hepatitis**?

If yes, which type? Hepatitis A Hepatitis B Hepatitis C Other

12. Have you ever had **liver disease**? YES NO

13. Have you ever had **varicose veins**? YES NO

14. Have you ever had **phlebitis**? YES NO

15. Have you ever had a **blood transfusion**? YES NO

16. Do you have **asthma, emphysema** or **chronic bronchitis**? YES NO

17. Do you have or have you ever had **leukemia**? YES NO

If yes, please describe treatment: _____

Medical History (continued)

18. Do you have or have you ever had **lymphoma**? YES NO
If yes, please describe treatment: _____
19. Do you have or have you ever had **colon cancer**? YES NO
If yes, please describe treatment: _____
20. Do you have or have you ever had **colon polyps**? YES NO
If yes, please describe treatment: _____
21. Do you have or have you ever had **multiple myeloma**? YES NO
If yes, please describe treatment: _____
22. Do you have or have you ever had **lung cancer**? YES NO
If yes, please describe treatment: _____
23. Do you have or have you ever had **rectal cancer**? YES NO
If yes, please describe treatment: _____
24. Have you ever had any problems with your blood? YES NO
If yes, please list the problem (such as anemia or excess blood cells): _____
25. Please list all **major surgeries, operations and hospitalizations** (including year and reason):

26. Have you ever had any **anesthesia complications**? YES NO
If yes, please describe: _____
27. Have you ever had your **cholesterol** checked? YES NO
If yes, what was the date it was last checked? _____
How was your cholesterol? Low Normal High
28. Do you have **arthritis**? YES NO
If yes, please describe: _____
29. Do you have **lupus**? YES NO
30. Do you have **scleroderma**? YES NO
31. Do you have **rheumatoid arthritis**? YES NO
32. Have you had **blood clots** in your legs or lungs? YES NO
33. Do you have problems with **water retention**? YES NO
34. Do you have problems with **swelling**? YES NO

Medical History (continued)

35. Do you have problems with **bloating**? YES NO

36. Do you have **osteopenia**? YES NO

If yes, please describe treatment: _____

37. Do you have **osteoporosis**? YES NO

If yes, please describe treatment: _____

38. Do you suffer from **hair loss**? YES NO

39. Do you suffer from or have you had **acne**? YES NO

Social History

1. Do you smoke cigarettes? YES NO

Average number smoked per day: _____ How many years have you been smoking? _____

2. Do you use recreational drugs? YES NO

3. Do you drink alcohol? YES NO

If yes, what type of alcohol do you drink? _____

How many drinks per week, on average, do you drink? _____

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Family History

1. Please circle **YES** for those that apply to **YOUR FAMILY** (on both your mother's/maternal or father's/paternal side). Next to each statement please list the relationship to you.

		If YES , who in your family history?
Alcoholism	YES NO	
Anemia	YES NO	
Arthritis	YES NO	
Asthma	YES NO	
Cancer of the breast	YES NO	
Cancer of the colon	YES NO	
Cancer of the ovaries	YES NO	
Cancer of the prostate	YES NO	
Cancer of the uterus	YES NO	
Cancer, other unspecified	YES NO	
Colon polyps	YES NO	
Depression	YES NO	
Diabetes	YES NO	
Glaucoma	YES NO	
Heart disease (CAD)	YES NO	
Elevated Cholesterol	YES NO	
Hypertension	YES NO	
Osteoporosis	YES NO	
Pulmonary embolism/DVT	YES NO	
Stroke	YES NO	
Thyroid disease	YES NO	

2. At what age did your mother go through menopause? _____

Physician Signature _____

Riley Perry Lloyd, MD FACOG

Date _____