

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 TELEPHONE W/ AREA CODE

(_____) _____
WORK TELEPHONE W/ AREA CODE

EMAIL: _____ @ _____

OCCUPATION

EMPLOYER

PLEASE CIRCLE: SINGLE LIFE PARTNER MARRIED SEPARATED DIVORCED WIDOW

REFERRED BY: _____

EMERGENCY CONTACT NAME

RELATIONSHIP TO PATIENT

(_____) _____
AREA CODE & TELEPHONE OF EMERGENCY CONTACT

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

Be Well Family Care
11495 N. Pennsylvania Street, Suite #270
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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Riley Perry Lloyd, MD, FACOG

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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Riley Perry Lloyd, MD, FACOG

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: MALE

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Primary Care Physician Name: _____

Physician Phone Number: _____ Date of Last Physical: _____

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

2. Please list any medications you are currently taking and the dosage amount: _____
_____3. Do you have any **drug allergies**? YES NOIf yes, please list the drugs you are allergic to: _____
_____4. Do you have any thyroid problems? YES NOIf yes, which type? Low Function Overactive Goiter Hashimoto5. Are you using any form of Testosterone or Hormone Therapy? YES NO

If yes, please describe _____

Symptom Checklist*Please indicate if you have the following:*

	YES	NO		YES	NO
Do you have erectile dysfunction?				Anxiety	
Is intercourse satisfying?				Irritability	
Do you initiate intercourse?				Mood swings	
Do you achieve orgasm?				Migraines	
Do you suffer from premature ejaculation?				Memory loss	
Is your sex drive similar as it was five (5) years ago?				Foggy thinking	
How often do you have intercourse?				Muscle loss	
Fatigue				Poor response to exercise	
Decrease in energy level				Poor recovery from exercise	

Please describe below the way in which the issues on the previous page have been dealt with:

Prostate & Testicular History

1. Age of first intercourse experience: _____
2. Are you currently sexually active? YES NO
3. Have you had any sexually transmitted diseases (STD's)? YES NO
Please list: _____
4. Have you had a sperm count? YES NO
What were the results of the sperm count? _____
5. Have you had the mumps? YES NO
When did you have the mumps? _____
6. Have you ever had testicular cancer? YES NO
If yes, when did this occur? _____
What type of treatment did you receive? _____
7. Do you have prostate problems? YES NO
8. Do you have or have you ever had prostatitis? YES NO
9. Is your prostate enlarged? YES NO
10. Have you ever had prostate cancer? YES NO
If yes, when did this occur? _____
What type of treatment did you receive? _____
11. Have you ever had blood in your urine? YES NO
If yes, when did this occur? _____
Please describe treatment used: _____
12. Do you have bladder or kidney issues? YES NO
If yes, please describe current treatment: _____

Medical History

1. Have you experienced weight gain in the last 1-2 years? YES NO

If yes, please describe: _____

2. Have you lost more than 10 pounds in the last month? YES NO

If yes, why? _____

3. Have you ever had leukemia or lymphoma? YES NO

If yes, what type? _____

Please describe treatment used: _____

4. Do you have a heart murmur? YES NO

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

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

If yes, please name the disorder: _____

7. Have you ever had rheumatic fever? YES NO

8. Do you have mitral valve prolapses? YES NO

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

10. Have you ever had hepatitis? YES NO

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

11. Have you ever had liver disease? YES NO

12. Have you ever had varicose veins? YES NO

13. Have you ever had phlebitis? YES NO

14. Have you ever had a blood transfusion? YES NO

15. Do you have a lung disease? YES NO

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

Medical History (continued)

17. Do You have lupus, scleroderma, or collagen disease? YES NO

18. Do you have arthritis? YES NO

If yes, what type? _____

19. Have you ever had any problems with your blood? YES NO

If yes, please list the problem (such as anemia or excess blood cells): _____

20. Have you ever had multiple myeloma? YES NO

Please describe treatment used: _____

21. Have you had any major accidents? YES NO

Please describe: _____

22. Please list all operations/hospitalizations (including year and reason): _____

25. Have you ever had any anesthesia complications? YES NO

If yes, please describe: _____

26. 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 Hig

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? _____

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	

Physician Signature _____

Riley Perry Lloyd, MD FACOG

Date _____