Ada West DERMATOLOGY
1618 S. Millennium Way, Suite 100
Meridian, ID 83642
(208) 884-3376

PEDIATRIC PATIENT INFORMATION

Patient Name:_____
(Last) (First) (MI)

Date of Birth: _____ Gender: ☐ Male ☐ Female

Parent or Legal Guardian Name: _____
(Last) (First) (MI)

Driver's License #: _____

Address: _____
(Street) (City) (State) (Zip)

_____ _____ _____
(Home Phone Number) (Work Phone Number) (Cell Phone Number)

How do you prefer to receive appointment reminders? ☐ Home phone (land line) ☐ Cell phone (text only) ☐ Email

Is it okay to leave a detailed message regarding minor on your answering machine/voicemail if you are unavailable? ☐ Yes ☐ No

Please provide your email address **(Please PRINT clearly)**:_____

DEMOGRAPHIC INFORMATION

√	Preferred Language
	English
	Spanish
	Other:
	Unspecified

√	Race
	Decline to Specify
	White
	American Indian or Alaska Native
	Asian
	Black or African American
	Native Hawaiian or other Pacific Islander
	Other Race

√	Ethnicity
	Decline to Specify
	Hispanic or Latino
	Not Hispanic or Latino
	Unknown

PREFERRED PHARMACY (Name, Street and City):_____

PRIMARY CARE PHYSICIAN (FIRST AND LAST NAMES):_____

IN CASE OF EMERGENCY NOTIFY (a person other than yourself):_____

Phone: ( )_____ Relationship to Patient:_____

ASSIGNMENT OF BENEFITS: I hereby assign all applicable benefits and direct that payment be made directly to Ada West Dermatology for all services provided to/for me during my visits.

RELEASE OF INFORMATION: I authorize Ada West Dermatology to furnish medical and other information necessary to process claims on my behalf. This information may be released to my personal physician and, upon request, to any other healthcare provider who may need the information for continuity of care. This release of information will remain in effect until revoked by me in writing.

MEDICATION HISTORY CONSENT: By signing below, I authorize Ada West Dermatology to access my relevant pharmacy prescription data (including medication history from other medical providers) electronically through SureScripts or similar programs.

TREATMENT AUTHORIZATION: The patient willfully requests treatment and consents to services provided by, or at the direction of the physicians, their physician assistants, or their nurse practitioner. I authorize a copy of this document to be used in place of the original.

NOTICE OF PRIVATE PRACTICES: As required by law, I have been given the opportunity to read the notice describing information about privacy practices followed by Ada West Dermatology.

_____ **Date**_____
Signature of Parent or Legal Guardian

HISTORY AND INTAKE FORM

Past Medical History: (please check all that apply)

	NONE		Depression		Hepatitis
	Anxiety		Diabetes		Leukemia
	Asthma		GERD		Radiation Treatment
	Bone Marrow Transplantation		Hearing Loss		Seizures

Other:_____

Past Surgical History: (please check all that apply)

	NONE		Skin Biopsy		Tonsils and Adenoids
	Ear Tubes		Skin Surgery		
	Hernia		Tonsils		

Other:_____

Skin Disease History: (please check all that apply)

	NONE		Dry Skin		Poison Ivy
	Acne		Eczema		Precancerous Moles
	Blistering Sunburns		Hay Fever/Allergies		Psoriasis

Other:_____

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 skin cancer?

Yes No

If yes, which relative(s)?_____

Medications: (Please list all current medications or attach a current medication list)

Name	Strength	How many?	How often?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

FOR OFFICE USE ONLY: Medications reviewed by _____

Patient Last Name, First Name:	DOB:

Allergies: (please list all allergies)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Tobacco Use: (tobacco in all its forms, including vaping and smokeless tobacco)

	Never Used Tobacco
	Quit: Former Tobacco User
	Uses Tobacco Less Than Daily
	Uses Tobacco Daily

Flu Vaccination:

Date of most recent influenza immunization: _____

Family History: (please select all that apply)

	Mother	Father	Sister(s)	Brother(s)	Grand-mother	Grand-father			
Autoimmune disorder									
Malignant melanoma									
Malignant neoplasm (Basal or Squamous Cell)									
Skin disease									
Other:									

Alerts: Do you have any of the following? (please check yes or no)

Alert	Yes	No
Allergy to latex		
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial or damaged heart valve		
Artificial joints within past two years		
Blood thinners		
MRSA		
Pacemaker		
Premedication prior to procedures		
Rapid heart beat with epinephrine		
Pregnancy or planning a pregnancy		

Ada West DERMATOLOGY

Dermatology
Dermatopathology
Mohs Micrographic Surgery

Patient Name_____ Date of Birth_____ Date:_____

INSURANCE INFORMATION (If you are "SELF PAY" check here and skip this section) ☐

Primary Insurance		Secondary Insurance	
Policy or ID Number		Policy or ID Number	
Subscriber's Name	Relationship to Patient	Subscriber's Name	Relationship to Patient
Subscriber's Social Security #	Subscriber's Date of Birth	Subscriber's Social Security #	Subscriber's Date of Birth
Subscriber's Employer		Subscriber's Employer	

FINANCIAL POLICY (Please Read Carefully)

Ada West Dermatology is committed to providing quality medical services at reasonable cost. In order to ensure effective communication between you and our practice, we have adopted the following financial policy. If you have any questions concerning this policy, please discuss them with our billing department.

Patients ***with insurance coverage*** are ultimately responsible to understand the specifics of their individual insurance policies. The patient retains ultimate responsibility for financial charges. Please contact your insurance company at the phone number provided on the back of your insurance card for your policy details.

Patients ***without insurance coverage*** are ultimately responsible for financial charges. We request payment of services prior to visit/procedure.

We may provide services in our facility, such as blood work or pathology that is sent to outside sources. If your insurance requires specific providers of service to be used, or if you have any questions regarding the cost of service, please notify a staff member before services are rendered.

We request payment of co-payment, deductibles and co-insurances at time of visit and/or procedure upon check-out. If this is not possible please discuss with our billing department before services are rendered. If you are unable to make your payment at check-in, you may be asked to reschedule your appointment.

I understand and agree that I am responsible for payment of all charges including those not paid by my insurance in a reasonable time. Small balance credits of less than $1.00 will be written off of my account. Unpaid balances over 30 days will accrue 1.5% interest monthly.

Please have a current copy of your insurance card. If proof of insurance is not provided, you will be expected to make payment in full.

If there are any questions or concerns of cost of services, please ask to speak with a member of our billing department. If you are unable to make your payment at check-in, you may be asked to reschedule your appointment.

We are disclosing this policy to you now to avoid a misunderstanding in the future.

We are very sensitive to your individual financial constraints. If necessary, we encourage patients to contact our billing department to arrange an acceptable payment schedule.

PLEASE NOTE: An outstanding balance of 90 days will be sent to to an outside agency for collections.

****I have read and understand this policy and my questions have been answered to my satisfaction.****

Patient/Guardian Signature:_____Date:_____

Ada West
DERMATOLOGY
Diseases of the Skin, Hair, Nails, & Skin Cancer Treatment

CONSENT TO TREAT UNACCOMPANIED MINOR (Optional)

I, _____, as the parent/legal guardian
Print Full Name of Parent or Legal Guardian

of _____, with a birth date of
Print Full Name of Minor Patient

_____ / _____ / _____, hereby grant Ada West Dermatology and its medical personnel permission to treat the minor listed above in my absence.*

***I understand that as the patient's parent/legal guardian, I must accompany them to their first visit, as well as to any additional visits where the minor listed above presents with a new medical concern.**

_____ _____
Parent/Legal Guardian Signature Date

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