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

PEDIATRIC PATIENT INFORMATION

Name_____
(Last) (First) (MI)

Driver's License #:_____ Social Security #:_____

Birthdate:_____ Gender: ☐ Male ☐ Female State/Country of Birth_____

Legal Guardian or Parent Name_____
(Last) (First) (MI)

Address_____
(Street) (City) (State) (Zip)

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

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

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

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

DEMOGRAPHIC INFORMATION

Preferred Language
☐ English
☐ Spanish
☐ Other_____
☐ Unspecified

Race
☐ Unspecified
☐ White
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ Other Race

Ethnicity
☐ Unspecified
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

PREFERRED PHARMACY (Store and Location) _____

PRIMARY CARE PHYSICIAN (first and last names)_____

IN CASE OF EMERGENCY NOTIFY (a number different than your own):_____

Phone ( )_____ Relation 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 Patient or Legal Guardian

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HISTORY AND INTAKE FORM

NAME:_____ **DATE OF BIRTH:**_____ **MALE ☐ FEMALE ☐**

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Benign Prostatic Hyperplasia
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Other Medical History _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Heart: Coronary Artery Bypass
Heart: PTCA
Heart: Mechanical Valve Replacement
Heart: Biological Valve Replacement
Heart: Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed
Ovaries: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
Prostate: TURP
Skin Biopsy
Skin: Basal Cell Cancer Surgery
Skin: Squamous Cell Cancer Surgery
Skin: Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

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? Yes No
If yes, which relative(s)? _____

Patient Last Name, First Name:_____ **DOB:** _____

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

	Name	Strength	Dosage	Frequency
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

When did you last receive your influenza immunization? _____

Have you received your Pneumonia vaccinations? Yes_____ No_____

Allergies: (Please enter all allergies)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Illicit Drug Use:
- None
- Drug Use
- IV Drug Use

Safety:
- I feel safe at home.
- I do not feel safe at home.

Occupation: _____

Family History: (Please select all that apply)

	Mother	Father	Sister(s)	Brother(s)	Mom's Mother	Mom's Father	Dad's Mother	Dad's Father	Daughter(s)	Son(s)
Autoimmune disorder										
Breast cancer										
Colon cancer										
Diabetes mellitus type 1										
Diabetes mellitus type 2										
Endocrine disease										
Heart disease congenital										
Heart disease ischemic										
Hemophilia										
High blood pressure										
High cholesterol										
Kidney disease										
Liver disease										
Lung cancer										
Malignant melanoma										
Malignant neoplasm (Basal or Squamous Cell)										
Mental disorder										
Ovarian cancer										
Prostate cancer										
Skin disease										
Stroke										
Thyroid disorder										
Other:										

Alerts: Are you currently experiencing any of the following? (please check yes or no for the following)

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

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

CONSENT TO TREAT UNACCOMPANIED MINOR

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 at their first visit as well as to any visit that the minor listed above presents with new problem.

_____ _____
Parent/Legal Guardian Signature Date

1618 S. Millennium Way, Suite 100 • Meridian, ID 83642 • 208-884-3376 / Fax 208-884-0858

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 policy. 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 a staff member 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.

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 contacting 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:_____