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)

Parent/Guardian Date of Birth: _____ 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.

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

HISTORY AND INTAKE FORM

Past Medical History: (please check all that apply) ☐ **NONE**

	Anxiety		Diabetes		Leukemia
	Asthma		GERD		Radiation Treatment
	Bone Marrow Transplantation		Hearing Loss		Seizures
	Depression		Hepatitis		

Other:_____

Past Surgical History: (please check all that apply) ☐ **NONE**

	Ear Tubes		Skin Biopsy		Tonsils and Adenoids
	Hernia		Skin Surgery		

Other:_____

Skin Disease History: (please check all that apply) ☐ **NONE**

	Acne		Eczema		Precancerous Moles
	Basal Cell Carcinoma		Hay Fever/Allergies		Psoriasis
	Blistering Sunburns		Melanoma		Squamous Cell Carcinoma
	Dry Skin		Poison Ivy		

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)

☐ **NONE**

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

FOR OFFICE USE ONLY: Medications reviewed by _____

Patient Name:	DOB:

Allergies: (please list all allergies) ☐ **NONE**

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) ☐ **NONE**

	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: _____

☐ **Check here if you are "SELF PAY" (skip insurance section, read financial policy, sign and date form)**

INSURANCE INFORMATION (Please Fill Out Completely)

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

I have read and understand the financial policy written below and my questions have been answered to my satisfaction

Signature of Patient/Guardian: _____ Date: _____

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 require payment of services prior to the visit and/or procedure.

We may provide services in our facility, such as blood work or pathology, that are 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 require 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 this 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 provide a current copy of your insurance card. If proof of insurance is not provided, you will be required to make payment in full.

If there are any questions or concerns about 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 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 greater than 90 days will be sent to an outside agency for collections.

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

CONSENT TO TREAT UNACCOMPANIED MINOR (Optional)

Patient Name: _____ Date of Birth: _____

I, _____, as the parent or legal guardian of the above listed 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.**
- **This consent will expire on the minor patient's eighteenth birthday; or may be revoked in writing by me, the parent/legal guardian, at any time (except to the extent that action has already been taken based on this consent).**
- **To revoke this consent, please contact our Health Information Manager.**

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____ Date: _____