

Main Clinic
1618 S Millennium Way Ste 100
Meridian ID 83642
(208) 884-3376

Ada West DERMATOLOGY

Ten Mile Clinic
4574 N Ten Mile Rd Ste 120
Meridian ID 83646
(208) 884-3376

PEDIATRIC PATIENT INFORMATION

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

Date of Birth: _____ Birth Gender: Male Female

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

Parent/Guardian Date of Birth: _____ **Driver's License #:** _____

Address: _____
(Street or PO Box) (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/voicemail if you are unavailable? Yes No

Email Address: **(Please PRINT clearly):** _____

DEMOGRAPHIC INFORMATION

√	Preferred Language
	English
	Spanish
	Other:

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

√	Race
	Decline to Specify or Other Race
	White
	American Indian or Alaska Native
	Asian
	Black or African American

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

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

Phone: _____ Relationship to Patient: _____

PREFERRED PHARMACY: Name: _____ Street: _____ City: _____

PRIMARY CARE PHYSICIAN: Last Name: _____ First Name: _____

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 (please circle *one*) _____ **Date:** _____

Parent or Legal Guardian Name (please **PRINT**): _____ **Authority:** _____

Ada West DERMATOLOGY

Patient Name:	DOB:
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Past Medical History: (please check all that apply) NONE

Anxiety
Asthma
Bone Marrow Transplantation
Depression

Diabetes
GERD/Acid Reflux
Hearing Loss
Hepatitis

Leukemia
Radiation Treatment
Seizures

Other: _____

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

Adenoids Removed
Tympanostomy (Ear Tubes)

Hernia Repair
Skin Biopsy

Tonsils Removed

Other: _____

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

Acne
Basal Cell Carcinoma
Blistering Sunburns
Dry Skin

Eczema
Hay Fever/Allergies
Melanoma
Poison Ivy

Precancerous Moles
Psoriasis
Squamous Cell Carcinoma

Other: _____

Do you wear Sunscreen?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, what SPF? _____
Do you <i>currently</i> tan in a tanning bed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Do you have a family history of Melanoma skin cancer? (Melanoma only , not Basal Cell or Squamous Cell Carcinoma)		
<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, which relative(s)? _____	

Medications: (Please list all current medications or attach a current medication list) or mark: NONE

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

Ada West DERMATOLOGY

Patient Name: _____	DOB: _____
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Allergies: (please list all allergies) or mark: **NONE**

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Immunizations:

Date of most recent influenza immunization: _____

Alerts: Do you have any of the following? (Please mark yes or no)

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

Ada West DERMATOLOGY

Patient Name:	DOB:
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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. 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

Patient Name:

DOB:

FINANCIAL ACKNOWLEDGMENT

1. Co-pay, co-insurance and deductibles will be collected at check out.
2. Ada West Dermatology will submit your claim to your insurance company for all charges incurred at the time of service.
3. Uninsured patients are required to make payment at check-in. At check-out, the full balance is due for additional charges.
4. After your insurance company processes the claim, you may receive the following additional charges:
 - a. Office visit co-pay
 - b. Charges for procedures performed by the provider
 - c. Pathology costs
 - d. Additional pathology tests
5. I understand and agree that I am responsible for payment of all charges, including those not paid by my insurance.

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Patient Name: _____

DOB: _____

**CONSENT TO TREAT
UNACCOMPANIED MINOR
(Optional)**

I, _____, as the parent and/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.
- Treatment for all **new** medical concerns must be authorized in writing by a parent or legal guardian.
- This consent will expire on the patient's eighteenth birthday; or 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 Department. Ph: (208) 813-3248

Printed Name of Parent/Legal Guardian: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____