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

DEMOGRAPHIC & INFORMATION

Preferred Language:	**Race:**
English	Decline to Specify
Spanish	White
Other:	American Indian or Alaska Native
	Asian
	Black or African American
	Other:

PARENT/LEGAL GUARDIAN INFORMATION

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

Parent/Legal Guardian Date of Birth: _____ **Guarantor's Social Security #:** _____

Parent/Legal Guardian Address: _____
(Street or PO Box) (City) (State) (Zip)

Parent/Legal Guardian Phone: _____
(Home Phone) (Work Phone) (Cell Phone)

Parent/Legal Guardian Email (please PRINT clearly): _____

Preferred Appointment Reminder: ☐ Phone ☐ Email ☐ Text ☐ Decline Reminders

Is it ok to leave a detailed message regarding minor on your voicemail if you are unavailable? ☐ YES ☐ NO

Emergency Contact: _____ Relationship: _____ Phone: _____

Preferred Pharmacy: Name: _____ Street: _____ City: _____

Primary Care Physician: Last Name: _____ First Name: _____

☐ Check here if you are uninsured (skip insurance information, read financial policy, sign & date form below)

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	

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Patient Name: **DOB:**

☐ **Check here only if you are uninsured, meaning you do not carry or have insurance. Read the policies & sign below.**

POLICIES FOR TREATMENT

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 Sure-Scripts 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.

NOTICE OF PRIVACY PRACTICES: As required by law, I have been given a copy of the Notice of Privacy Practices followed by Ada West Dermatology.

FINANCIAL POLICY

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.

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. Co-pay, co-insurance and deductibles will be collected at check out. Ada West Dermatology will submit your claim to your insurance company for all charges incurred at the time of service.

Patients ***with insurance coverage*** are 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 responsible for financial charges. We require payment of services prior to the visit and/or procedure. Uninsured patients are required to make payment at check-in. At check-out, the full balance is due for additional charges.

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. After your insurance company processes the claim, you may receive the following additional charges: Office visit co-pay, Charges for procedures performed by the provider, Pathology costs, and Additional pathology tests.

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.

No Show fees: Appointment no-shows or cancellations less than 24 hours in advance will be charged $35.

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 collection.

I have read and understand the treatment and financial policy. I certify that all my questions have been answered to my satisfaction.

Signature of Patient *or* Representative: _____ **Date:** _____

Personal Representative Name: _____ **Authority:** _____

(If signed by the patient's Personal Representative, please **print name** and describe authority to act for the individual)

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Minor Patient Name: **DOB:**

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

	Anxiety		GERD/Acid Reflux		Radiation Treatment
	Asthma		Hay Fever/Allergies		Seizures
	Depression		Hearing Loss		
	Diabetes		Leukemia		

Other: _____

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

	Bone Marrow Transplantation		Tonsils/Adenoids Removed
	Laser Treatments		Tympanostomy (Ear Tubes)
	Skin Biopsy		

Other: _____

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

	Acne		Dry Skin		Precancerous Moles
	Basal Cell Carcinoma		Eczema		Psoriasis
	Blistering Sunburns		Melanoma		Squamous Cell Carcinoma

Other: _____

Do you wear sunscreen? ☐ YES ☐ NO

If YES, what SPF? _____

Do you currently tan in a tanning bed? ☐ YES ☐ NO

Do you have a family history of Melanoma Skin Cancer? ☐ YES ☐ NO

If YES, which relative(s)? _____

(**Melanoma ONLY**, not Basal Cell Carcinoma or Squamous Cell Carcinoma)

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

Name	Strength	How Many?	How Often?
1.			
2.			
3.			
4.			
5.			

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

1
2
3
4
5

Immunizations: Date of most recent influenza immunization:_____

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

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

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Minor 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 and/or legal guardian, I must accompany them to their first visit.
- Treatment for all **new** medical concerns must be authorized in writing by a parent and/or legal guardian.
- This consent will expire on the patient's eighteenth birthday; or may be revoked in writing by the parent and/or 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:** _____