Ada West
DERMATOLOGY

PEDIATRIC PATIENT INFORMATION-Page 1

Name:_____
(Last Name) (First Name) (Middle Name)

Date of Birth:_____ **Birth Sex**: ☐ Male ☐ Female **Gender Identity**:_____
(Optional)

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

PARENT/LEGAL GUARDIAN INFORMATION

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

Parent/Legal Guardian Date of Birth:_____

Parent/Legal Guardian Address:_____
(Street or P.O. Box) (City) (State) (Zip)

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

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

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

Parent/Legal Guardian Email (Please print clearly):_____

Emergency Contact:_____
(Name) (Relationship) (Phone)

Preferred Pharmacy:_____
(Name) (Street) (Phone)

Primary Care Physician:_____
(Last Name) (First Name) (Phone)

Primary Care Address:_____
(Street or PO Box) (City) (State) (Zip Code)

INSURANCE INFORMATION (Required)

☐ **Check here if you are uninsured. (Skip insurance information, read financial policy, sign & date.)**

Primary Insurance:_____ **Policy or ID #**_____

Primary Policy Holder Name:_____ **Date of Birth**:_____

Primary Policy Holder Relationship to Patient:_____

Primary Policy Holder's Employer:_____

****

Secondary Insurance:_____ **Policy or ID#**_____

Secondary Policy Holder Name:_____ **Date of Birth**:_____

Secondary Policy Holder Relationship to Patient:_____

Secondary Policy Holder's Employer:_____

Ada West
DERMATOLOGY

PEDIATRIC PATIENT INFORMATION-Page 2

Minor Patient Name: **DOB:**

Past Medical Conditions (Please check all that apply)

□ None	□ Diabetes	□ Leukemia
□ Anxiety	□ Gerd/Acid Reflux	□ Radiation Treatment
□ Asthma	□ Hay Fever/Allergies	□ Seizures
□ Depression	□ Hearing Loss	□ Other:

Past Surgeries (Please check all that apply)

□ None	□ Bone Marrow Transplantation	□ Heart valve replacement
□ Biopsy of skin	□ Tonsils/Adenoids Removed	□ Other:
□ Excision of melanoma	□ Tympanostomy (Ear Tubes)	□ Other:

Skin Conditions (Please check all that apply)

□ None	□ Dry Skin	□ Psoriasis
□ Acne	□ Eczema	□ Squamous Cell Carcinoma
□ Basal Cell Carcinoma	□ Melanoma	□ Other:
□ Blistering Sunburns	□ Precancerous Moles	□ Other:

Skin Protection

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

□ None	□ Daughter	□ Niece
□ Mother	□ Son	□ Grandmother
□ Father	□ Uncle	□ Grandfather
□ Sister	□ Aunt	□ Grandson
□ Brother	□ Nephew	□ Granddaughter

Ada West
DERMATOLOGY

PEDIATRIC PATIENT INFORMATION-Page 3

Patient Name: **DOB:**

Medications: ☐ **None** or please list all current medication information below or ☐ Current medication list is attached

Name of medication/supplement	Strength (i.e. 100)	Unit (i.e. mg)	Dosage (How Many)	Frequency (How Often)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Allergies: ☐ **None** or please list all allergies below.

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

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

Condition/Alert	Yes	No	Condition/Alert	Yes	No
Allergy to Latex			Defibrillator		
Allergy to Adhesive			MRSA		
Allergy to Lidocaine			Pacemaker		
Allergy to Topical Antibiotic Ointments			Premedication Prior to Procedures		
Artificial Heart Valve			Rapid Heartbeat with Epinephrine		
Artificial Joints Within the Past Two Years			Pregnancy or Planning a Pregnancy		
Blood Thinners					

Ada West
DERMATOLOGY

PEDIATRIC PATIENT INFORMATION-Page 4

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

Parent or Legal Guardian (Please circle one)

Printed Name: _____ **Date:** _____

Signature: _____ **Date:** _____

Ada West
DERMATOLOGY

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. Ada West Dermatology will submit your claim to your insurance company for all charges incurred at the time of service.

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.

Patients ***with insurance coverage*** are responsible for understanding 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 any Additional pathology tests.

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 my account.

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:** _____

If Personal Representative, Name: _____ **Authority:** _____

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