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 unavailable? ☐ Yes ☐ No

Parent/Legal Guardian Email:_____

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

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

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

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:_____

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Secondary Insurance:_____ Policy or ID#_____

Secondary Policy Holder Name:_____ Date of Birth:_____

Secondary Policy Holder Relationship to Patient:_____

Secondary Policy Holder's Employer:_____

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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

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PEDIATRIC PATIENT INFORMATION - Page 3

Minor Patient Name: **DOB:**

Medications: ☐ **None**, ☐ **List** all current medication information below, ☐ **Current** medication list 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 Past Two Years			Pregnancy or Planning a Pregnancy		
Blood Thinners					