Family Dermatology Co.

# Minor Registration Packet

**Patient Name & Info** **Today's Date: ________________**

| First: | Middle initial: | Last: |
|---|---|---|

| Date of Birth: | Social Security #: | Gender: Male or Female |
|---|---|---|

| Race: | Ethnicity: | Language: |
|---|---|---|

**Parent/Guardian Information**

| **Name:** | **Relationship:** | **Phone #:** |
|---|---|---|
| **Name:** | **Relationship:** | **Phone #:** |

**Contact information**

| Best Phone (primary):<br>________________________________<br>May we leave a detailed message at this number? **YES** **NO** | Alternate Phone:<br>________________________________<br>May we leave a detailed message at this number? **YES** **NO** |
|---|---|

| **Email Address:** |
|---|

| **Emergency Contact Name:** | **Phone:** |
|---|---|
| Relationship to Patient: | |

**Mailing Address**

(Please provide the mailing address for any correspondence)

| Street Address or PO Box: | | Apartment Number (If any): |
|---|---|---|
| City: | State: | Zip: |

**Name of primary care provider:** ________________________________________

**Referring provider:** ____________________________________________

**Insurance Information**

| Please complete all information even though it may be printed on your insurance card. | | |
|---|---|---|
| **Primary Insurance** | Subscriber/Member ID: | Subscriber is the patient's:<br>□ Father □ Mother □ Other ____________ |
| **Secondary Insurance** | Subscriber/Member ID: | Subscriber is the patient's:<br>□ Father □ Mother □ Other ____________ |
| Subscriber's Name: | | Date of Birth: |

**Pharmacy of choice:** ____________________________________________

Phone number: __________________________

Do we have permission to import the patient's medications from their pharmacy into our electronic medical records system, if possible? **YES NO**

With whom may we discuss the patient's medical condition/information with?

**Name:** _________________________________________________________

**Relationship to patient:** ______________________

# Missed Appointments/Cancellation Policy

**First and foremost, we would like to thank you for being a patient in our office!**

We value all of our patients and strive to provide the best care possible. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.

We kindly ask that if you must change an appointment, or if you are unable to keep an appointment, please call as soon as you can and **please give at least 24 hours' notice**. This courtesy makes it possible to give your reserved time to another patient who would like it.

If an appointment is not cancelled or rescheduled at least 24 hours in advance, you may be charged a $25 fee for phototherapy appointments, a $50 fee for regular appointments, and a $250 fee for surgery appointments. **These fees will not be covered by your insurance company**.

By signing, you are agreeing that you acknowledge and understand the above information.

**Responsible party signature:** ___________________________________ **Date:** _____________

Family Dermatology Co.

# **Financial Policy**

For billing questions, please call: 855-298-6837

**Thank you for taking the time to read our financial policy.**

If you are self-pay (no insurance) or are here for a cosmetic appointment, your balance is due at the time of service. Co-pays required by your insurance policy are also due at the time of service.

We bill your insurance as a courtesy to you, but you are ultimately responsible for payment. You are also responsible for understanding how your insurance works. If your insurance denies a claim due to inaccurate or incomplete information you provided to either us or them, we may bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance company before seeking payment from you. We will help you as best we can to get proper and timely payment from your insurance company.

If we do not have a contract with your insurance carrier, then the total financial responsibility is determined by our prices for the services rendered.

Please pay your bill promptly by calling our billing company at your earliest convenience. Balances extremely past due may be subject to collections. In all cases, our billing company will attempt to contact you as a courtesy before these measures are taken.

***** We ask that you please provide us with the most current insurance you have. You are responsible for any charges you may receive due to not updating our office with any insurance changes. It is your responsibility to update us with any changes made throughout the year.**

My signature below indicates that I understand and agree to this financial policy.

**Responsible party signature:** ______________________________________________

**Date:** _________________

## Family Dermatology Co.

# Consent to Treat a Minor Patient Without a Parent/Legal Guardian Present

It is our policy that anyone under the age of 18 years old cannot be seen by themselves without written consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we **must** have written permission from the parent or legal guardian that this person has been appointed by you to act of your behalf. We require a parent or guardian to be present in the exam room with children under the age of 13. Any child over the age of 13 may be seen by themselves, but only if their parent or guardian is present in the building and/or can easily be reached by phone. We also require that this form be filled out as well.

| Minor's name: | Date of birth: |
|---|---|
| | |

For those occasions when you may not be with your child, **please list those individuals who may give us consent to see your child:**

| **Name:** | **Relationship to patient:** |
|---|---|
| **Name:** | **Relationship to patient:** |

● **Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state, "none")**

______________________________________________________________________

**AUTHORIZATION**

I (parent/legal guardian name) ________________________________ request and authorize Family Dermatology and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient at the time of service.

I have the legal right to preauthorize Family Dermatology and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, injections, lab work (examples: culture swabs, blood draws), wart treatment with liquid nitrogen, minor suturing of biopsies, patch testing, Cantharidin (canthacur), and prescribing prescriptions.

**I have read, understand, and give my consent as outlined above.**

| **Parent/legal guardian printed name:** | |
|---|---|
| **Parent/legal guardian signature:** | **Date:** |

Today's Date: _________________ Date of Birth: ________________

Patient Name: (First, middle, and last) ________________________________________

**Past Medical History:** (Please circle and list all that apply) ...........**NONE**

| | | |
|---|---|---|
| Anxiety | Elevated Blood Pressure | Hypercholesterolemia |
| Arthritis | End-stage Renal Disease | Hyperthyroidism |
| Asthma | Epilepsy | Hypothyroidism |
| Atrial Fibrillation | GERD | Leukemia |
| Depression | Hypertension | Malignant Lymphoma |
| Diabetes | HIV | Malignant Tumor |

______________________________________________________________________

______________________________________________________________________

**Past Surgical History:** (Please circle and list all that apply) .........**NONE**

| | | |
|---|---|---|
| Appendix Removal | Hysterectomy | Hip Replacement (Left, Right, Bilateral) |
| Bone Marrow Transplant | Kidney Transplant | |
| Heart Valve Replacement | Knee Replacement (Left, Right, Bilateral) | |

______________________________________________________________________

______________________________________________________________________

**Skin History:** (Please circle and list all that apply) ..................**NONE**

| | | |
|---|---|---|
| Acne | Eczema | Psoriasis |
| Actinic Keratosis | Hay Fever | Squamous Cell Carcinoma |
| Basal Cell Carcinoma | Melanoma | Sunburn |

______________________________________________________________________

______________________________________________________________________

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**

If yes, which relative? _________________

**Medication Allergies:** (Please list all allergies to medications)

| | |
|---|---|
| Medication: | Reaction: |
| Medication: | Reaction: |
| Medication: | Reaction: |

Other allergies: ____________________________________________________________

**Medications:** Please enter all current prescription and over-the-counter medications including supplements. You may also provide a list if you have one available.

| Name of medication: | Strength: (Ex: mg, mcg, ml) | Route: (oral, tablet, capsule, topical) | How often: (How many times a day?) | Approximate date you started this medication: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Social History:** (Please circle all that apply)

**Cigarette Smoking:**

Currently smokes
Never smoked
Former smoker – Quit __ months/years ago

**Alcohol Use:**

None
Less than one drink per day
1-2 drinks per day

**Review of Systems:** Are you currently experiencing any of the following?

| | Yes | No |
|---|---|---|
| **Problems with bleeding** | | |
| **Problems with healing** | | |
| **Problems with scarring** | | |
| **Immunosuppression** | | |
| **Changing mole** | | |
| **Rash** | | |

Other symptoms: ______________________________________________

**Alerts:** (Please circle all that apply)

Pacemaker
Defibrillator
Artificial joints within the past two years
Artificial heart valve
Premedication prior to procedures
Allergy to adhesive
Allergy to topical antibiotics ointments
Blood thinners

Pregnancy or planning a pregnancy
Allergy to lidocaine
Latex allergy
Rapid heartbeat with epinephrine
Yeast infections with antibiotics
GI upset with antibiotics
Hepatitis A, Hep B, or Hep C
HIV

**Patient or responsible party signature:** ______________________________

**Date signed:** ____________________ 