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:_____

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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:_____

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

Minor 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

Minor Patient Name: **DOB:**

Consent to Treat Unaccompanied Minor (Optional)

I, _____, as the parent and/or legal guardian of the
(Printed Name of Parent or Legal Guardian)
above listed patient, hereby grant Ada West Dermatology (AWD) and its medical personnel permission to treat the minor listed above in my absence.

- As the patient's parent and/or legal guardian I understand that I am required to accompany my minor child to their first visit. If I am not able to attend an appointment with my minor child, I will complete and sign all required consents prior to the appointment.

I authorize Ada West Dermatology to treat the minor for (choose 1):

- ____ Any and all dermatologic conditions (preferred)
- ____ Treatment of only the following condition(s): _____

_____

(please note that if you choose this option and the minor presents for, or asks about any additional issues, we will not be able to address those issues on that day and will have to reschedule a time when a parent or guardian can be present at the appointment).

- Treatment for all **new** medical concerns, not listed above, 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)

Signature: _____ **Date:** _____