

# Patient Health History Form

## PATIENT INFORMATION

**Patients Legal Name:** \_\_\_\_\_  
*Name that child likes to be called (Nickname):* \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **Current Age:** \_\_\_\_\_

## SOURCES OF INFORMATION

**Name of Person Providing Information:** \_\_\_\_\_  
**Relationship to child:** \_\_\_\_\_  
 Best Phone # parent may be reached during the day: \_\_\_\_\_  
 \_\_\_\_\_  
 Primary/Preferred Language:  ENGLISH  SPANISH  OTHER: \_\_\_\_\_

## CHIEF COMPLAINT: *Please be as specific as possible*

**Reason(s) for today's visit:** \_\_\_\_\_  
 \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS AND REVIEW OF SYSTEMS

Is your child having any of the following problems **TODAY**?

Itching	No ___/ Yes ___	
Blisters	No ___/ Yes ___	
Fever	No ___/ Yes ___	
Hair Loss	No ___/ Yes ___	
Sores	No ___/ Yes ___	
Warts	No ___/ Yes ___	
Pain/ Tenderness	No ___/ Yes ___	
Birthmarks	No ___/ Yes ___	
Eye/ Ear symptoms	No ___/ Yes ___	
Nose/ Throat Symptoms	No ___/ Yes ___	
Weight Gain	No ___/ Yes ___	
Weight Loss	No ___/ Yes ___	
Headaches	No ___/ Yes ___	
Nausea/ Vomiting	No ___/ Yes ___	
Diarrhea	No ___/ Yes ___	
Abdominal Pain	No ___/ Yes ___	
Swollen Lymph Nodes	No ___/ Yes ___	
Changes in Vision	No ___/ Yes ___	
Cough	No ___/ Yes ___	
Shortness of Breath	No ___/ Yes ___	
Pain/ Difficulty Urinating	No ___/ Yes ___	
Depression/ Anxiety	No ___/ Yes ___	

## PAST HISTORY

**Are immunizations UP TO DATE?** No \_\_\_/ Yes \_\_\_

**Is your child allergic to any medications or to LATEX?** No \_\_\_/ Yes \_\_\_  
*If yes, please List:* \_\_\_\_\_

**Does your child have a genetic condition or syndrome?** *If yes, please list:*  
 \_\_\_\_\_  
 \_\_\_\_\_

**\*\*REFERRED BY:** Doctor \_\_\_\_\_

## PAST MEDICAL AND SOCIAL HISTORY

**Has child ever been hospitalized or had any serious illnesses or injuries?**  
 If yes, please list: \_\_\_\_\_

**Has your child ever had any operations?** If yes, please list: \_\_\_\_\_

**Does child have an artificial heart valve or require antibiotics before dental work or other procedures?** No \_\_\_/ Yes \_\_\_

**\*Adolescents: Is your child sexually active?** No \_\_\_/ Yes \_\_\_

**Does your child smoke/use alcohol?** No \_\_\_/ Yes \_\_\_

**\* Female Patients: Has she started menstrual cycles?** No \_\_\_/ Yes \_\_\_

*If menstruating: When was last cycle* \_\_\_\_\_

**Is there any chance she could be pregnant?** No \_\_\_/ Yes \_\_\_

## PATIENT MEDICAL HISTORY

Check the appropriate box that applies to the **PATIENT** or **IMMEDIATE** family members that have or have had any of the following conditions:

CONDITION	CHILD	FAMILY
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Immune Suppression	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Non-Melanoma Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Problems/Depression	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

**Do any other skin disorders run in the family?** No \_\_\_/ Yes \_\_\_  
*If yes, please List:* \_\_\_\_\_

## MEDICATIONS

**Is your child taking any medications:** No \_\_\_/ Yes \_\_\_  
*If yes, please List: (include topical creams or herbal medications):*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



TODAY'S DATE: \_\_\_\_\_

# Patient Demographics Form

Please complete the following information:

## PATIENT'S INFORMATION

PATIENT'S NAME \_\_\_\_\_  
 Last First Middle

PRIMARY ADDRESS \_\_\_\_\_  
 Street Apt City State Zip Code

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ MALE \_\_\_\_ FEMALE \_\_\_\_ E-MAIL: \_\_\_\_\_

## PARENT'S INFORMATION

Child **PRIMARYLY** lives with? \_\_\_\_ Both Parents \_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_ other \_\_\_\_\_

Parent's Marital Status: \_\_\_\_ Divorced \_\_\_\_ Married \_\_\_\_ Single \_\_\_\_ Separated

Who is legally/court appointed to make medical decisions? \_\_\_\_\_

### GIVE BOTH PARENTS INFORMATION – INSURED FIRST:

Insured Parent Name: _____	Other Parent Name: _____
Insured Parent DOB: _____	Other Parent DOB: _____
Insured Parent Phone #: _____	Other Parent Phone #: _____
Insured Parent Employer: _____	Other Parent Employer: _____
Insured Parent Occupation: _____	Other Parent Occupation: _____

EMERGENCY CONTACT: \_\_\_\_\_ PHONE \_\_\_\_\_  
*Name & Relationship to patient*

PATIENT'S PRIMARY CARE DOCTOR \_\_\_\_\_  
 Name City/State Phone

Which Doctor referred you to our office? \_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_ PHARMACY PHONE #: \_\_\_\_\_

**Consent for Care:** I give permission for the following people to bring my child to his/her appointments.  
*(Responsible for medical decisions and payment at the time of visit)*

\_\_\_\_\_  
 \_\_\_\_\_

\*In case of emergency, parent can be reached at \_\_\_\_\_.

I hereby state that the above information is current and correct, and authorize the release of any information required to complete this or any future claim and also authorize payment of medical benefits to me, for professional services to K. Robin Carder, MD of Pediatric Dermatology of Dallas, PA. I further authorize a copy of this authorization to be used in place of the original.

**BY SIGNING BELOW, I AGREE TO PAY ALL EXPENSES REGARDLESS OF INSURANCE RESPONSIBILITY.**

\_\_\_\_\_  
 Signature Date



## Office Policy

*Please read completely*

**Your medical insurance is designed to assist you, the policyholder, with your medical fees.** However, few policies provide complete coverage. Payment of our fee is your responsibility and is due in full at the time of service. As a courtesy to you, we will file insurance for medical care with the following understanding:

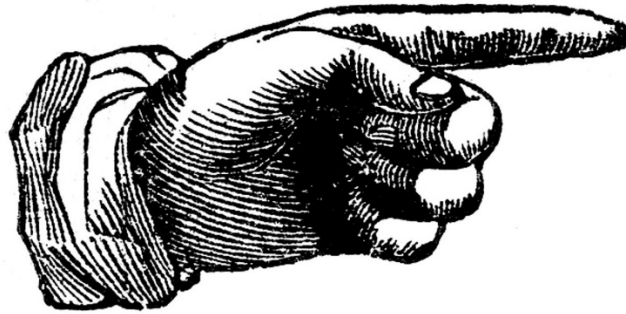
1. Patient agrees to pay any portion of our fee that the insurance company will not cover. This would include deductibles, uncovered expenses and co-payment. **\*It is the patient's responsibility to ensure that all necessary referrals/authorizations are obtained for medical care.** If these are not obtained, the patient is responsible for all charges.
2. **As a courtesy to you,** we will file your claim(s) with the sufficient information given. If for any reason, you are unable to provide us the insurance within a timely manner with all necessary and correct information, you will be billed for the services rendered to you. It is the patient's responsibility to provide the office correct/current information.
3. **Patient agrees to monitor his or her own claims** filed with the insurance company, by calling and checking the status of claims until the claim has been paid.
4. **Assignment of benefits is accepted for a period of 60 days** from the date our office submits the initial claim to your carrier. Should your insurance company fail to provide benefits within this period of time; your remaining balance will become due and payable. If payment is not received within a timely manner your account could be turned over for collection with possible interest and collection fees added to your balance due. If payment arrangements are needed, please call the office immediately so that we may assist you and avoid in further action.
5. **Certain medical conditions such as: scars, hair loss, skin tags** may be considered ***COSMETIC*** by your insurance plan and may **NOT** be covered by you insurance carrier and evaluation/treatment of these conditions **MAY NOT BE COVERED.**
6. **E-MAILS:** To protect your privacy, our office does **NOT** accept medical questions, photos, appointments or refill requests via email. Our e-mail is **NOT** encrypted (**NOT SECURED**).
7. **A returned check fee of \$35.00 will be posted to your account and may be turned over for collection.**
8. **NO SHOW/LATE CANCELLATION:** We understand that appointments may need to be rescheduled on occasion due to emergency or illness, however our office requires **24 hour notice (1 FULL BUSINESS DAY PRIOR)** of cancellation. If an appointment is not kept, or is not cancelled 24 hours prior to the scheduled appointment time (***regardless of reason***), you will be subject to a **\$50 fee.** ***\*NOTE: Monday appointments MUST call to cancel/reschedule by the preceding Friday to avoid fee.***
9. **Some insurance plans consider procedure (including skin scrapings, wart or molluscum treatment) to be a surgery.** ***As such, these procedures may be subject to a separate deductible.***

We appreciate the opportunity to participate in your care and hope this explanation of policy will eliminate any misunderstandings associated with your insurance benefits.

As the responsible party, I accept the terms of this insurance office policy and authorize payment of insurance benefits to the doctor in charge of my care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Please Notice This



WARTS AND/OR MOLLUSCUM OFTEN REQUIRE MORE THAN ONE TREATMENT

**TREATMENT OF WARTS AND/OR MOLLUSCUM BY “BEETLEJUICE” (CANTHARONE)/ FREEZING, ETC IS CONSIDERED AS AN IN OFFICE SURGICAL PROCEDURE BY MOST INSURANCE COMPANIES**

THIS MEANS THE PROCEDURE COST MAY HAVE A COINSURANCE OR BE APPLIED TO YOUR DEDUCTIBLE. THIS AMOUNT WILL BE DUE AT THE TIME OF VISIT. WE HAVE A LIST OF INSURANCE ALLOWABLE COSTS AT THE FRONT DESK, AND CAN NOTIFY YOU OF THE COST PRIOR TO THE PROCEDURE.

**FYI--THERE ARE PRESCRIPTION AND OVER THE COUNTER PRODUCTS AVAILABLE, IF YOU CHOOSE NOT TO HAVE AN IN-OFFICE TREATMENT DONE.**

**\*\*Remember there are no guarantees when it comes to treating warts and/or molluscum. Multiple treatments may be needed.**



**PLEASE NOTIFY DR. CARDER WHICH OPTION YOU PREFER.**

**THANK YOU,**

**DR. CARDER'S STAFF**



## PATIENT HIPAA AUTHORIZATION FORM

*Please read completely*

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment payment health care operations. You have the right to revoke this disclosure, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

**The patient or their parent or guardian understands that:**

Protected health information may be disclosed or used for treatment, payment or health care operations

- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this authorization in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Authorization.

I acknowledge that I have read the above authorization and have had access to read Pediatric Dermatology of Dallas' full Notice of Privacy Practices (upon request):

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Printed Name-Patient or Representative

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Relationship to patient

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Signature

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\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date