

CHILDREN'S SKIN CENTER, PA/GABLES SKIN CENTER

PLEASE PRINT CLEARLY-Favor completar con letra legible

Patient Information

Información del Paciente

Patient's Name: _____ Social Security # _____
Nombre del Paciente #Seguro Social

Date of Birth: _____ Age: _____ Male: Female
Fecha de nacimiento Edad Hombre Mujer

Permanent Address: _____
Domicilio Permanente

City: _____ State: _____ Zip Code: _____
Ciudad Estado Código Postal

Home Number: _____ Preferred Number
Número Casa Número preferido

Mobile Number: _____ Preferred Number
Número Celular

International Patients:

Pacientes Internacionales

Local Phone # _____ Local Contact: _____
Teléfono Local Contacto Local

Email: _____ Passport #: _____
Correo Electrónico Pasaporte #

Parent/Guardian Information for Minors

Padre o Tutor Información para Menores

Mother's Name: _____ Father's Name: _____
Nombre de Madre Nombre de Padre

Mother's Home #: _____ Father's Home #: _____
#Domicilio de la Madre # Domicilio del Padre

Mother's Mobile #: _____ Father's Mobile #: _____
Celular de la Madre # Celular del Padre

Mother's Email: _____ Father's Email: _____
Correo Electrónico de la Madre Correo Electrónico del Padre

Emergency Contact

Contacto de Emergencia

Name: _____ Phone Number: _____
Nombre # Teléfono

Relationship to Patient: _____
Relación con el Paciente

Medical Information:

Información Médica

Primary Physician's Name: _____ Primary's Phone #: _____
Nombre del Doctor Primario # Teléfono del Primario

Name of Doctor that referred you: _____
Nombre del Doctor que le refiere

Insurance information (Please provide copies of Insurance cards & drivers license or other photo ID)
(Información sobre cobertura de seguros- por favor provea copia de tarjetas de seguros y licencia de conducir u otra identificación con foto)

Subscriber's Name: _____ Subscriber's Date of Birth: _____
Nombre del Suscrito Fecha de nacimiento del suscrito

We will only leave telephone messages regarding your appointment, or when we are trying to contact you.
Solamente dejaremos mensajes telefónicos con respecto a su cita o cuando estemos tratando de contactarle

- I have received the Office Privacy Notice *He recibido la información sobre Privacidad*
- I have received the Office Welcome Brochure *He recibido el folleto de Bienvenida*

Signature of Person Responsible for Payment:

Firma de la persona responsable del pago _____

CHILDREN'S SKIN CENTER, PA/GABLES SKIN CENTER

CONSENT FOR TREATMENT

Patient : _____ Date _____

1. I, the undersigned consent to undergo all necessary tests, medication, and treatments and other procedures required in the course of the study, diagnosis and treatment of my illness by Dr. Duarte.
2. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantee has been made to me as to the result of examinations, treatments or operations.
3. I hereby authorize Dr. Duarte's staff to take such still photographs as may be required.
4. I hereby authorize Dr. Duarte to retain, preserve, and use for scientific research, therapeutic, or teaching or commercial purposes, or dispose of at her convenience any specifications, organs, or tissues taken from my body.
5. I authorize my medical records and results to be used by Dr. Duarte or her research personnel. My records will not be identified as pertaining to me specifically in any publication without my expressed permission.
6. I consent to the release of medical information to other institutions or agencies accepting the patient for medical or institutional care and consent to the release of medical information to my referring physician and to any person or corporation which is or may be liable under a contract to the hospital or physician(s) or to the patient or to the family member or employer of the patient for all or part of the hospital's and physician(s) charges, including but not limited to, insurance companies, workers compensation carriers, welfare funds, or the patients employer. I consent to the release of medical information to my next of kin or my designee in the event of my expiration.
7. I hereby assign payment directly to Dr. Duarte. Accepting this assignment of all hospitalization and medical benefits applicable and otherwise payable to me but not to exceed the hospital's and physician's regular charges for this period of treatment. I understand that I am financially responsible to the physician(s) for charges not covered by this assignment or for any and all charges which the insurance or other sources may apply to any other account owed to said hospital an physicians(s) by the insured or his/her family. I agree that a photo copy of this authorization is as valid as the original.
8. I agree, whether I sign as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of the physician(s) in accordance with the regular rates and terms of the physician(s). Should the account be referred to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses.
9. I understand that I may need to continue treatment with Dr. Duarte. Appointments will be given to me at time which is convenient to me I will allow courtesy of 24 hours if I should need to reschedule my appointment. That will enable Dr. Duarte to offer that slot to another patient. If I should not adhere to this policy, I will be charged \$10.00 for a missed appointment.

I hereby read and clearly understand the above:

Patient's signature or one who is legally authorized to sign

Parent or Guardian

Minors consent: Patient's under 18 years of age must have the signature of parent(s) or Guardian(s).

CHILDREN'S SKIN CENTER, PA/GABLES SKIN CENTER

Dear Patient:

This letter is to clarify our office's and your insurance company's policy on cosmetic and non-covered services. Non-covered services and cosmetic services are those procedures and services that are deemed by the insurer to be not medically necessary. Your insurance policy specifically states that non-medically necessary procedures are not covered. This includes the removal of such things as moles, skin tags, and other benign growths that are clinically benign and non irritated. This also includes the removal of ugly spots and brown aged related spots. This also includes treatment for port wine stains, hemangiomas, and any laser treatment as well as chemical peels.

Since these procedures are not covered by your insurance, you may have options. The first option is to do nothing. If, however, you wish to have a non-covered procedure for cosmetic or other reasons, you can have that procedure done in our office or by any other physician you might choose. In either case the cost will be explained prior to the procedure being done, and you will be asked to sign a disclosure statement.

It is very important that you understand your choices so that there is no misunderstanding or confusion. A copy of this letter will remain signed in our chart as proof of this understanding.

Patient name: _____ Patient signature: _____

IF YOU WISH TO RECEIVE NON-MEDICALLY NECESSARY SERVICES, PLEASE SIGN:

I have read the statement above, and I understand that I will be responsible to pay full charges for this procedure.

Procedure in question: _____

Reason for non-medical necessity: _____

Approximate Cost: _____

Date: _____ Patient signature: _____

E-mail: pediderm@aol.com Visit our web site at: www.childrensskincenter.com

CHILDREN'S SKIN CENTER, PA/GABLES SKIN CENTER

Date:

Patient Name:	
Reason for visit today:	
Duration of Condition:	
Symptoms:	
Treatments Tried:	
What has helped:	
What makes it worse:	
List all allergies to medications:	
List all history of family illness:	
List all medical conditions:	
List all hospitalizations:	
List all medications taken daily:	
Last visit to a doctor:	Name of Doctor:
What was the reason for the visit?	

CIRCLE AND INITIAL ALL THAT APPLY

INITIALS:

Completed by: Patient Guardian Parent Medical Assistant Physician Nurse Practioner Physician Assistant

I have reviewed the information, verified its accuracy, and made additions or corrections as required

MD/PA/NP Signature: _____

Past History, Review of Systems and Social History

Page 1

Name: _____ Date of birth: _____

Sex: Male _____ Female _____ Weight: _____ Ht.: _____

Health History:/ Review of Systems

- 1. Have you ever had asthma, emphysema or bronchitis? Yes _____ No _____
- 2. Have you ever had tuberculosis? Yes _____ No _____
- 3. Have you ever had difficulty breathing? Yes _____ No _____
- 4. Do you have any lung disease? Yes _____ No _____
- 5. Do you have high blood pressure? Yes _____ No _____
- 6. Do you have heart disease? Yes _____ No _____
- 7. Do you have or have you had irregular heartbeats (arrhythmia's) Yes _____ No _____
- 8. Are you requested to take antibiotics before dental work? Yes _____ No _____
- 9. Have you ever had ulcers or other stomach or intestinal problems? Yes _____ No _____
- 10. Have you had liver disease, hepatitis, or jaundice? Yes _____ No _____
- 11. Have you ever had any kidney, urinary, or prostate problems? Yes _____ No _____
- 12. Do you have diabetes? Yes _____ No _____
- 13. Have you ever had trouble with your thyroid glands? Yes _____ No _____
- 14. Have you ever had cancer? Yes _____ No _____
- 15. Have you ever had a stroke, seizures, or fainting spells? Yes _____ No _____
- 16. Have you ever had a heart attack? Yes _____ No _____
- 17. Do you have any unusual problems with you eyes, ears, nose, mouth or throat? Yes__ No ____

ROS

- 1. Have you ever had cataracts or cataract surgery? Yes _____ No _____
- 2. Have you ever had an auto-immune disorder such as lupus or Scleroderma? Yes _____ No _____
- 3. Do you have arthritis? Yes _____ No _____
- 4. Do you have any immune deficiency disorders? Yes _____ No _____
- 5. Have you ever been treated for psychiatric or emotional problems? Yes _____ No _____
- 6. Are you currently under treatment? Yes _____ No _____
- 7. Have you ever been treated by a dermatologist? Yes _____ No _____
- 8. If yes, by whom and when were you treated? Yes _____ No _____
- 9. Have you ever had eczema either as a child or adult? Yes _____ No _____
- 10. Have you ever been told you have psoriasis? Yes _____ No _____
- 11. After an accidental or surgical wound have you ever formed an overgrown thickened scar or keloid? Yes _____ No _____
- 12. Do you bleed excessively after a tooth extraction or surgical treatment? Yes _____ No _____
- 13. Do your wounds heal poorly? Yes _____ No _____
- 14. Have you ever had an x-ray or gamma ray treatments for your skin? Yes _____ No _____
- 15. Have you ever had skin cancers? Yes _____ No _____
- 16. Have you had a sexually transmitted disease? Yes _____ No _____
- 17. Are you allergic to any drugs or food? Yes _____ No _____
If yes which one(s): _____
- 18. Are you taking any prescriptions or medications? Yes _____ No _____
If yes, please specify? _____
- 19. Are you taking any nonprescription medications (over the counter) such as aspirin, antihistamines or laxatives? Yes _____ No _____
- 20. Do you have any medical problems not asked about in the above? Yes _____ No _____
If yes, what problems: _____

If completing, please initial all that apply: Patient: ____
Physician: ____
Medical Assistant: ____
Physician Assistant: ____
Nurse Practioner: ____

Past History, Review of Systems and Social History
Page 2

FOR FEMALES:

21. Are you still having menstrual periods? Yes _____ No _____
 22. Is your menstrual cycle regular? Yes _____ No _____
 23. Have you ever had any problems with your ovaries such as polycystic ovary disease? Yes _____ No _____
 24. Are you pregnant now or planning a pregnancy in the near future? Yes _____ No _____
 25. Are you currently using contraceptives? Yes _____ No _____

FAMILY HISTORY: Has any member of your family had the following

26. Diabetes Yes _____ No _____
 27. Lupus or Scleroderma Yes _____ No _____
 28. Melanoma or atypical moles Yes _____ No _____
 29. Skin Cancer Yes _____ No _____
 30. Asthma, eczema or hives? Yes _____ No _____

SOCIAL HISTORY:

31. What is your occupation: _____
 32. Have you ever used street drugs such as cocaine, crack, PCP, or LSD? Yes ___ No _____
 33. Have you ever used intravenous drugs? Yes _____ No _____
 34. Do you currently drink alcoholic beverages? Yes _____ No _____
 35. Do you smoke cigarettes? Yes _____ No _____
 36. How many packs per day _____
 37. Have you ever had significant sun exposure and or sunburn? Yes _____ No _____
 38. Do you use sunscreens? Yes _____ No _____

SYSTEM REVIEW: SKIN

39. Do you have significant, persistent, or intermittent itching on your skin? Yes _____ No _____
 40. Have you ever had any new hair growth on your face, chest, abdomen? Yes _____ No _____
 41. Do you have any new moles or blemishes or any significant change in existing moles? Yes _____ No _____

When you go into the sun do you (Please choose one)

42. Always burn, never tan Yes _____ No _____
 43. Usually burn, tan with difficulty Yes _____ No _____
 44. Sometimes burn, usually tan Yes _____ No _____
 45. Rarely burn, tan easily Yes _____ No _____

BIRTH HISTORY (infants and babies)

Birth Weight: _____

APGAR Score: _____

Delivery: Vaginal
 C-Section, why? _____

Complications: _____

CIRCLE AND INITIAL ALL THAT APPLY

INITIALS:

Completed by: Patient Guardian Parent Medical Assistant Physician Nurse Practioner Physician Assistant

I have reviewed the information, verified its accuracy, and made additions or corrections as required

MD/PA/NP Signature: _____

REVIEW OF SYSTEMS

Name: _____ Date: _____

Please Circle All Applicable

General / Constitutional

Average weight, weight loss or gain, general state of health, sense of well-being, strength, ability to conduct usual activities, exercise tolerance

Skin/Breast

Rash, itching, pigmentation, moisture or dryness, texture, changes in hair growth or loss, nail changes, Breast lumps, tenderness, swelling, nipple discharge

Eyes/Ears/Nose/Mouth/Throat

Headaches (location, time of onset, duration, precipitating factors), vertigo, light-headedness, injury vision, double vision, tearing, blind spots, pain, nose bleeding, colds, obstruction, discharge dental difficulties, gingival bleeding, dentures, neck stiffness, pain, tenderness, masses in thyroid or other areas

Cardiovascular

Precordial pain, substernal distress, palpitations, syncope, dyspnea on exertion, orthopnea, nocturnal paroxysmal dyspnea, edema, cyanosis, hypertension, heart murmurs, varicosities, phlebitis, claudication

Respiratory

Pain (location, quality, relation to respiration), shortness of breath, wheezing, stridor, cough (time of day, productive, amount in tablespoon or cups per day and color of sputum), hemoptysis, respiratory infections, tuberculosis (or exposure to tuberculosis), fever or night sweats

Gastrointestinal

Appetite, dysphagia, indigestion, food idiosyncrasy, abdominal pain, heartburn, eructation, nausea, vomiting, hematemesis, jaundice, constipation, or diarrhea, abnormal stools (clay-colored, tarry, bloody, greasy, foul smelling), flatulence. Hemorrhoids, recent changes in bowel habits

Genitourinary

Urgency, frequency, dysuria, noturia, hematuria, polyuria, oliguria, unusual (or change in) color of urine, stones, infections, nephritis, hesitancy, change in size of stream, dribbling acute retention or incontinence, libido, potency, genital sores, discharge, venereal disease
(Female) Age of onset of menses, regularity, last period, dysmenorrhea, menorrhagia, or metrorrhagia, vaginal discharge, post-menopausal bleeding, dyspareunia, number and results of pregnancies (gravid, Para)

Musculoskeletal

Pain, swelling, redness or heat of muscles or joints, limitation of motion, muscular weakness, atrophy, cramps

Neurologic /Psychiatric

Convulsion, paralyzes, tremor, incoordination, parathesias, difficulties with memory of speech, sensory or motor disturbances, or muscular coordination (ataxia, tremor) predominant mood
"Nervousness" (define), emotional problems, anxiety, depression, previous psychiatric care, unusual perceptions, hallucinations

Allergic/Immunologic/Lymphatic/Endocrine

Reactions to drugs, food, insects, skin rash, trouble breathing, anemia, bleeding tendency, previous transfusions and reactions, RH incompatibility, local or general lymph node enlargement or tenderness. – polyuria, asthenia, hormone therapy, growth, secondary sexual development, intolerance to heat or cold

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MD/PA/NP: _____