Children's Skin Center
PEDIATRIC AND ADULT DERMATOLOGY

Tel: (305) 669-6555
Fax: (305) 668-5579
www.childrensskincenter.com

PLEASE PRINT CLEARLY-*Favor completer 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*

Cell Number: _____ ❑ Can we send text message to this number to confirm appointment?
¿Se puede mandar texto para confirmar sita?

Home Number: _____

Email: _____

Parent/Guardian Information for Minors
Padre o Tutor Información para Menores

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

Phone Number: *Numero de teléfono* _____ Phone number: *Numero de teléfono* _____

Emergency Contact
Contacto de Emergencia

Name: _____ Phone Number: _____
Nombre *# Teléfono*

Relationship to Patient: _____
Relación al Paciente

Medical Information:
Información Médica

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

Pharmacy Information
Información de farmacia

Pharmacy: _____ Phone Number: _____

We will only leave telephone messages regarding your appointment, or when we are trying to contact you. ***Solamente dejaremos mensajes telefonicos 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 responsible del pago _____

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CONSENT FOR TREATMENT

I, the undersigned consent to undergo all necessary tests, medication, and treatments and other procedures required in the course of the diagnosis and treatment of my illness by the healthcare providers at the Children's Skin Center, PA.

- 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.
- I hereby authorize the Children's Skin Center, PA staff to take photographs as may be required.
- 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.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

- I understand that the collection of my medical information will be used for the purpose of planning my care and treatment and communicating with other health care providers responsible for my health care.
- I consent to the release of my medical information to other institutions or agencies accepting the patient for medical or institutional care.
- I consent to the release of medical information to the following:
    1. my referring physician and to any person or corporation which is or may be liable under a contract to the physician(s)
    2. the patient or to the family member of the patient for all or part of the physician(s) charges, including but not limited to, insurance companies, workers compensation carriers, or welfare fund.
    3. I consent to the release of medical information to my next of kin or my designee in the event of my expiration.

ASSIGNMENT OF PAYMENT

- I hereby assign payment directly to the Children's Skin Center, PA for services rendered. Accepting this assignment of all medical benefits applicable and otherwise payable to me but not to exceed the 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 physicians(s) by the insured or his/her family.
- I agree that a photo copy of this authorization is as valid as the original.
- 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.

AUTHORIZATION TO ACT ON MY BEHALF TO INSURANCE CARRIERS

- I understand and give consent to Children's Skin Center to act on my behalf to submit claims and appeal claims to my insurance carrier.

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain right to privacy regarding my protected health information. I acknowledge that I've received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I hereby read and clearly understand the above:

_____ _____

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

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PATIENT MEDICAL HISTORY

Date:

Patient Name:
(Nombre del Paciente) _____

Reason for visit today:
(Motivo de visita) _____

Duration of Condition:
(Tiempo de condición) _____

Symptoms:
(Síntomas) _____

Treatments Tried:
(*Tratamientos probado)* _____

What has helped:
(Que ha ayudado) _____

What makes it worse:
(Que ha empeorado) _____

List all allergies to medications:
(Liste alergias a las medicinas) _____

- **Do you have a personal history of skin condition?**

¿Tienes historial personal de condición de piel? _____

- **Do you have a family history of skin condition?**

¿Tienes historial familiar de condición de piel? _____

- **List all history of family illness:**

(*Liste toda la historia clínica de las enfermedades de la familia)* _____

- **List all medical conditions:**

(Liste todas las condiciones médicas) _____

- **List all hospitalizations:**

(Liste todas las hospitalizaciones) _____

- **List all medications taken daily:**

(Liste todas medicinas que toma diariamente) _____

_____

_____

Last visit to a doctor:
(La última visita al médico)

Name of Doctor:
(Nombre del Doctor) _____

What was the reason for the visit?
(Motivo de visita) _____

I have reviewed the information, verified its accuracy, and made additions or corrections as required
MD/PA/NP Signature: _____