Dermatology Center
of Canyon County

Minor Patient Information

Minor's Name: ______________________________ ______________
Last First Middle Prefer to be called:

Date of Birth:____/____/____ Sex: ❑Female ❑Male Name of School________________

Address: ____
Street Apt # City State Zip

( ) ____________________ ( ) ____________________
Home Phone Alternative Phone Number

Legal Guardian or Parent Name ____________________ SSN#/DL#__________
Last First Initial

( ) ____________________ ( ) ____________________
Home Phone Alternative Phone Number

Insurance Information:

Primary Insurance Co:__________________ ID# ____________ Group # __________

Name of Policy Holder (Insured):__________________ Insured Date of Birth: ___/___/____

Employer Name:______________________________ Employer Phone:__________

Secondary Insurance Co:__________________ ID# ____________ Group #__________

Name of Policy Holder (Insured):__________________ Insured Date of Birth: ___/___/____

Employer Name: ______________________________ Employer Phone: __________

Payment Policy

The adult/guardian who brings in the child will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees. In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA/MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release medical information to the minor's primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

May we leave medical information about the minor on your answering machine at home? ❑YES ❑NO
May we e-mail personal medical information about the minor to you? ❑YES ❑NO
E-mail address:______________________________
Do you give our office permission to discuss medical information about your minor with family members? ❑YES ❑NO If yes, whom?

Name:__________________Relationship:______________ Phone:______________

Emergency Contact Information:

In case of emergency, whom should we notify?______________________________
Relationship to Patient Phone

Parent/Legal Guardian Signature______________________________ Date:____/____/______

Dermatology Center of Canyon County
NEW PATIENT

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Date: ______________________

Name: ______________________ Age:________

Referring MD: ______________________

Primary MD: ______________________

Check the appropriate box if you or your family members have had any of the following conditions:

CONDITION	you	mom	dad	other	CONDITION	you	mom	dad	other	CONDITION	you	mom	dad	other
Stroke					Asthma					Thyroid disease				
Diabetes					Emphysema					Arthritis				
Artificial valve					Hepatitis					Seasonal allergies				
Artificial joint					Seizures					Eczema				
Heart Disease					Organ transplant					Psoriasis				
High blood pressure					Immune suppression					Cancer Type:				
Chest pain					HIV or AIDS					Melanoma				
Pneumonia					Kidney disease					Skin cancer				
Other Health conditions. List:														

Do you have any allergies to medications? ❑No ❑Yes______________________

Are you currently pregnant? ❑No ❑Yes ❑N/A Are you planning a pregnancy? ❑No ❑Yes ❑N/A

Do you require antibiotics before dental work or other procedures? ❑No ❑Yes

Spouse's name (if applicable):__________________ Number of children (if applicable):______________

Do you smoke? ❑No ❑Yes Amount_________ Do you drink alcohol? ❑No ❑Yes Amount__________

Do you have any of the following symptoms?

Weight loss	❑Yes ❑No	Abdominal pain	❑Yes ❑No	Muscle/joint pain	❑Yes ❑No
Headache	❑Yes ❑No	Swollen Lymph nodes	❑Yes ❑No	Chest Pain	❑Yes ❑No
Fever	❑Yes ❑No	Change in vision	❑Yes ❑No	Jaundice	❑Yes ❑No
Fatigue	❑Yes ❑No	Cough	❑Yes ❑No	Pain/Difficulty urinating	❑Yes ❑No
Nausea/vomiting	❑Yes ❑No	Shortness of Breath	❑Yes ❑No	Depression	❑Yes ❑No
Diarrhea	❑Yes ❑No	Bleeding disorder	❑Yes ❑No	Other______________________	

Do you have a history of blistering sunburn? ❑Yes ❑No Do you wear sunscreen daily? ❑Yes ❑No

List all medications you are currently taking (include over-the-counter medications, vitamins and herbals).

Reason for today's visit:____

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