Minor Patient Registration Form

Minor's Name: ______________________________ Preferred to be called: ______________

Date of Birth _____/_____/_______ Sex: ☐ Male ☐ Female

Address: ______________________________City:_____________ State ____Zip:_________

Day Phone: (___) _____-______ Evening Phone: (____) _____-_______

Legal Guardian or parent: __________________________ **Date of Birth:**______________

Day phone: (_______) _________-______________ SSN:________________________

Address if Different from above:____

Payment Policy

The adult/guardian who brings the child in will be responsible for the bill including all copayments and deductibles we do not forward bills to other parties regardless of court rulings or divorce decrees.

Insurance Subscriber Information:

Responsible party: _____________ **Name of Parent:** __________________________

Parent's DOB: _______________ **Parent's SSN**______________________________

Secondary Insurance

Responsible party: _____________ **Name of Parent:** __________________________

Parent's DOB: _______________ **Parent's SSN**______________________________

May we leave medical information about the minor on your answering machine? Yes ☐ No ☐

Do you give the office permission to discuss medical information about your minor child with family members?

Name: ____________________________ Phone: (___) _____-_______

In case of emergency: whom shall we notify? ____________________________________

Relationship to patient: ___________________________ Phone: (_____) ______-_______

PRIMARY CARE PROVIDER: ___________________________________

Parent/ Legal Guardian Signature

____**Date**___/____/____

SCHOLES DERMATOLOGY

Scholes Dermatology, LLC
526 Shoup Ave W, Suite A
Twin Falls, ID 83301
208-734-5555

Consent for Treatment, Financial Agreement, and Records Release

Patient Name: ______________________________ **Date of Birth:** ____________

I, the undersigned as the patient (or authorized person), consent to any treatment and/or procedures rendered to me that may, under the judgement and instruction of the treating provider, be considered advisable or necessary. I understand that if any extensive procedure or surgery is to be procedure or surgery is to be performed, it will be fully explained to me, including the risks, benefits and alternatives, and my specific consent will be necessary. I voluntary give my consent for treatment and also my consent to any procedure that my provider performs in the dermatology clinic and deems necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridement of wounds, injections of skin lesions, cauterizations of skin lesions, surgery /electro cautery.

Initial ________

I understand that any ancillary services (x-rays, lab tests, pathology, slide prep etc.) that may be ordered be ordered by the medical provider while I am in the clinic are not included in my clinic bill and that I will be billed separately for those services.

In addition, I authorized **Scholes Dermatology, LLC** , along with any contracted provider or outside provider to furnish all medical and financial information related to for this visit to my insurance carrier and/or any agency working on their behalf. I hereby authorize payment of benefits on my behalf to any of the providers performing services related to this encounter. I understand that certain services may not be covered or may be denied by my insurance carrier and I hereby guarantee payment of the charges incurred and agree to pay any unpaid balances.

I, the undersigned, have read the above authorizations and understand the same and certify that no guarantees or assurances have been made as to the results or outcome of any treatment procedure or diagnosis.

______________________________ ______________________

Signature or Patient or legal Representative **Date**

Scholes Dermatology- Medical History

Name______________________________ Date of Birth______________________

Medical History: Do you now have (or have had in the past) and the following conditions? Please check all that apply:

- o Anxiety
- o Arthritis (Osteo)
- o Arthritis (RA)
- o Asthma
- o Atrial Fibrillation/ Irregular Heartbeat
- o Benign prostatic hyperplasia
- o Coronary arteriosclerosis (Heart Disease)
- o COPD
- o Depression
- o Diabetes
- o End stage renal disease
- o Epilepsy
- o Gastric Reflux (GERD)
- o Hypertenion
- o Hearing Loss
- o Hepatitis Type______
- o HIV/AIDS
- o High Cholesterol
- o Leukemia
- o Lymphoma
- o Lung Cancer
- o Breast Cancer
- o Colon Cancer
- o Prostate Cancer
- o Radiation Treatment
- o Seizures
- o Stroke
- o Thyroid
- o Transplant of bone marrow
- o Other disease not listed ______________________

Surgical History: Please check all that apply to you:

- o **No Previous Surgeries**
- o Appendix
- o Bladder Removal
- o Breast Biopsy
- o Breast Lumpectomy (Left)
- o Breast Lumpectomy (Right)
- o Breast Mastecotmy (Left)
- o Breast Mastectomy (Right)
- o Colon Surgery (Cancer)
- o Colon Surgery (Diverticulitis)
- o Colon Surgery (UC/Crohn)
- o Gall Badder
- o Heart Bypass (CABG)
- o Heart Stent
- o Heart Transplant
- o Heart Valve (Mechanical)
- o Heart Valve (biological)
- o Heart: PTCA
- o Hip Replacement (Left)
- o Hip Replacement (Right)
- o Knee Replacement (Left)
- o Knee Replacement (Right)
- o Kidney Biopsy
- o Kidney Transplant
- o Liver Transplant
- o Liver Shunt
- o Prostate Biopsy
- o Prostate Cancer
- o Prostate TURP
- o Oophorectomy
- o Rectum Resection
- o Skin Biopsy
- o Melanoma
- o Spleen (Splenectomy)
- o Testicles (Orchiectomy)
- o Hysterectomy (Fibroids)
- o Hysterectomy (Uterine Cancer)
- o Hysterectomy (Cervical Cancer)
- o Other surgeries not listed ______________________

Skin Disease History: Please check all that apply to you:

- o Acne
- o Actinic Keratoses
- o Posion Ivy
- o Dry Skin
- o Eczema
- o Flaking or Itchy Scalp
- o Hay fever/ Allergies
- o Asthma
- o Melanoma
- o Psoriasis
- o BCC- Where?___________
- o SCC- Where?____________
- o Sunburn of second degree (Blisters)

- o Other skin problems not listed:____

Do you wear sunscreen? Yes No What SPF? ______ Do you tan in a tanning salon? Yes No

Do you have a family history of Skin Cancer? Who?__________________________

Does anyone in your family have a history of Melanoma? Who?__________________________

Do you get your flu shot year? Yes No **If over 66- Have you had your Pnemonia Vaccine?** Yes No

Do you have a living Will? YES NO

Do you have a health care proxy in the event you are unable to make your own medical decisions? YES NO

Current Medications: Check here_____ if you take no medications.

________________ ________________ ________________

________________ ________________ ________________

Allergies to Medications: Please list any medications to which you are allergic: NONE

________________ ________________ ________________

________________ ________________ ________________

Which pharmacy do you use? ______________________ City______________________

Social History:

Occupation: ______________________________________

PRIMARY DOCTOR: ______________________________________

Smoking History: Please check one of the following:

- ☐ Never smoked
- ☐ Current every day smoker- **Cigarettes/ E-Cig/Vape**
- ☐ Chewing Tobacco
- ☐ Current occasional smoker
- ☐ Former smoker

Alcohol history: Please check one of the following:

- ☐ None
- ☐ Less than one drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Female Patients:

Are you pregnant? Yes No Due date: ____________________

Are you breast-feeding Yes No