PERRY
DERMATOLOGY

PEDIATRIC MEDICAL HISTORY FORM

Today's Date:____/____/_____

Name: _____ DOB:____/____/_____

Reason for Today's Visit: _____
Is your current skin condition (please circle) : Bleeding Itching Painful Growing Changing
Duration of skin condition: _____ Location: _____
Have you tried any medications in the past for your current condition? Y/N
If yes, please list: _____
Height: _____ft _____in Weight: _____lbs
Pediatrician: _____
Pharmacy Name: _____ Phone Number: (____)____-_____
Pharmacy Address: _____

PERSONAL MEDICAL HISTORY

Please mark yes for any medical conditions you have or have had in the past:

Eczema	**Y/N**	**Autoimmune Disease**	**Y/N**
Psoriasis	**Y/N**	**Liver Disease**	**Y/N**
Seasonal Allergies/Hay Fever	**Y/N**	**Thyroid Disorder**	**Y/N**
Asthma	**Y/N**	**Diabetes**	**Y/N**
Acne	**Y/N**	**Kidney Disease**	**Y/N**
Skin Cancer	**Y/N**	**HIV/AIDS**	**Y/N**
Keloid	**Y/N**	**Organ/Bone Marrow Transplant**	**Y/N**
Cancer (other than skin cancer)	**Y/N**	**Immunodeficiency**	**Y/N**
Other:			

If you answered yes to any of the above, please specify:

_____

_____

FAMILY MEDICAL HISTORY

If any blood relative has any condition listed below, check and specify which blood relative.
EX: Diabetes: (X) Maternal Grandmother

Allergies/Hay Fever: ( ) _____ Severe Acne: ( ) _____ Other Cancer: ( ) _____
Childhood Eczema: ( ) _____ Psoriasis: ( ) _____ Heart Disease: ( ) _____
Asthma: ( ) _____ Diabetes: ( ) _____ High Blood Pressure: ( ) _____
Hives: ( ) _____ Basal Cell Skin Cancer: ( ) _____ Autoimmune Disease: ( ) _____
Rosacea: ( ) _____ Squamous Cell Skin Cancer: ( ) _____ Melanoma: ( ) _____

SOCIAL HISTORY

Primary Caretaker: _____
Is your child in school or daycare: y/n If so what grade/level: _____
Siblings at home: _____
Frequency of bathing: _____ daily or _____ weekly
What soap is used for bathing: _____ Do you use a washcloth or loofah: y/n
Do you use a moisturizer or emollient: y/n If so which one: _____
Tobacco Use: Current Former Never If current, how many per day: _____
Alcohol Use: Current Former Never If current, how many per day: _____

MEDICATIONS AND ALLERGIES

Current medications: _____
_____
_____

Allergies: _____
_____

REVIEW OF SYSTEMS

Are you having any of these symptoms currently? If yes, please circle:

Fever, Chills, Nausea, Vomiting, Diarrhea, Constipation, Chest Pain, Shortness of Breath, Cough, Headaches, Numbness, Joint Pain, Changes in Vision, Unintended Weight Loss, Anxiety, Depression, Easy Bruising/Bleeding, Painful Urination

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: ____/____/_____ Race: Cau/His/AfrAm/Asian/Other/Decline
Gender: M/F Marital Status: Single/Married/Divorced/Separated/Widowed
Home Phone: (____) ____-_____ Cell Phone: (___) __-_____ Work Phone: (___) ___-_____
Email Address: _____
Preferred Method of Contact: _____
May we send you appointment reminders via text? Y/N
Mailing Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Job Title: _____
Emergency Contact Name: _____
Relationship to Patient: _____ Phone Number: (___)___-_____

INSURANCE INFORMATION

PLEASE ALLOW THE RECEPTIONIST TO MAKE COPIES OF YOUR INSURANCE CARDS AND DRIVER'S LICENSE

Primary Insurance
Company: _____ Member ID: _____
Policy Holder Name: _____ Policy Holder DOB:_____/_____/_____
Relationship to Policy Holder: Self: _____ Spouse: _____ Child: _____

Secondary Insurance
Company: _____ Member ID: _____
Policy Holder Name: _____ Policy Holder DOB:_____/_____/_____
Relationship to Policy Holder: Self: _____ Spouse: _____ Child: _____

Guarantor Information:
Person Responsible for Payment: Self: _____ Spouse: _____ Parent: ____ Other: _____
(Fill Out Below if Other Than Self)
First Name: _____ Last Name: _____ MI: _____
Address (if different from patient): _____
City: _____ State: _____ Zip:_____
Phone Number: (___)___-_____ Date of Birth: ___/____/_____ Gender: M/F

OFFICE POLICIES

Insurance claims will be filed for all medically necessary services if the office is credentialed with your insurance company. Copayments, previous balances, and self pay fees are due at the time of service. For any returned checks, there will be a $25 NSF fee that will be added to your account. Accounts that have a credit of less than $5 will not be refunded unless requested, but will remain in your account for future use.

If you are unable to make your scheduled appointment, we ask that you notify the office no later than 24 hours prior to your appointment. If you arrive 20 minutes or later after your scheduled appointment time, your appointment may be rescheduled. If we are able to keep your original appointment, you may have to wait longer than usual. We try our best to see patients in a prompt and timely manner. For patients who no-show to an excision/surgery appointment without canceling 24 hours prior to the procedure appointment, we reserve the right to apply a $75 charge.

- I hereby request the professional services of Perry Dermatology and have read and understand the above.
- I authorize payments to Perry Dermatology by my insurance company for all services rendered to me or to my dependents.
- I understand that I am financially responsible for all charges, whether or not paid by my insurance.
- I authorize the physician to release any information for my medical care or for insurance purposes as outlined in the Notice of Privacy Practices that I have received.
- I authorize the use of this signature on all insurance submissions.
- This authorization is in effect until terminated by the patient.
- I authorize the office to obtain prescription formulary information and information about other prescriptions given to me by other providers.
- I authorize this office to e-prescribe prescriptions on my behalf.

I authorize my medical information to be shared with the following persons:

Name: _____Relationship: _____ Phone: _____
Name: _____Relationship: _____ Phone: _____
Name: _____Relationship: _____ Phone: _____

Signature of Patient or Legal Guardian:

_____ Date: _____