BROWN DERMATOLOGY
BROWN PHYSICIANS, INC.

PEDIATRIC DERMATOLOGY NEW PATIENT QUESTIONNAIRE

Patient Name: _____ ***DOB:*** _____

PREFERRED NAME OF CHILD: _____

CHILD'S PEDIATRICIAN/PRIMARY CARE PROVIDER: _____

PEDIATRICIAN/PCP ADDRESS: _____

PHARMACY _____

WHO REFERRED YOU TO OUR PRACTICE FOR EVALUATION?

☐PEDIATRICIAN ☐DERMATOLOGIST (NAME:_____) ☐SELF

☐HOSPITAL ☐PHONE ☐INTERNET ☐OTHER _____

HISTORY

Please tell us about your child's skin problem: _____

When did problem FIRST start? _____

List all medications and treatments tried for this problem: _____

HEALTH HISTORY

Does your child have any past or present medical problems? (List) _____

Any past surgeries? (Please list) _____

Any past hospitaliztions? (Please describe) _____

FAMILY HISTORY

Please indicate ✔ if any family members have had the following problems?

GF=GRANDFATHER, GM=GRANDMOTHER, BRO=BROTHER, SIS=SISTER, OTHER=AUNTS,UNCLES,COUSINS

	MOM	DAD	SIS	BRO	GF	GM	OTHER
ECZEMA							
ASTHMA							
HAY FEVER							
PSORIASIS							
SKIN CANCER							
MELANOMA							
ABNORMAL MOLE							

SOCIAL HISTORY

Please list siblings and ages:

_____

_____

Child's primary caretaker (circle) Mom Dad Both Grandparent Other _____

Grade in school (circle) PreK 1 2 3 4 5 6 7 8 9 10 11 12 College

Pets at home? _____ Daycare: ☐ YES ☐ NO

Please flip to back side page ------>

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Patient Name: _____ ***DOB:*** _____

SUN HISTORY

Please describe patient's skin as closely as you can:

☐	Burns,freckles easily never tans	☐	Burns,occasionally tans readily
☐	Burns,easily tans poorly	☐	Never burns,tans well

Sunscreen Use

☐	Never	☐	Usually before spring or summer outdoor activity
☐	Occasionally	☐	Always before spring or summertime outdoor activity
☐	Sometimes before spring or summertime	☐	Year-round

Sunscreen type and SPF:_____ Tanning bed use: ☐ YES ☐ NO

CURRENT MEDICATIONS (Please list) _____

MEDICATIONS ALLERGIES OR SERIOUS FOOD ALLERGIES _____

REVIEW OF SYSTEMS

Please indicate whether your child has experienced any of these symptoms by checking YES (Y) or NO (N) for each

	Yes	No		Yes	No
Growth problems			Heart Problem		
Eye Problem			Joint Pain		
Ear, nose, throat			Muscle or bone problem		
Seizure			Fever		
Headaches			Swollen glands lymph nodes		
Jaundice or hepatitis			Learning disorder/school problem		
Weight Change			Poor Appetite		
Wheezing shortness of breath			Urinary Problems		

Child's interests, hobbies, activities: _____

Is there anything else you would like us to know? _____

Signature of the person filing out form_____ ***Date:***_____

Relation to Patient _____

MEDICAL TEAM USE ONLY

REVIEWED BY:_____

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Initial Visit Consent

PATIENT NAME:_____ DOB: _____

I understand that as part of my care the staff of Brown Dermatology, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

HIPAA Privacy Policy

I have been offered or received a copy of the Privacy Notice. It describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. To receive a copy of any revised Notice, please ask a front desk staff person or call the Privacy Officer at 401-270-1406.

Teaching Practice

Our physicians are full-time, teaching Dermatologists at Brown Alpert Medical School and in our role as teachers you may be seen by a resident, a physician that has already completed one or more years of post-medical school training, before being seen by your attending physician.

Photo Consent

I consent to be photographed regarding the medical dermatological condition or treatment for which I am seeing my provider at Brown Dermatology, Inc. for. These photographs may be used for my own medical and dermatologic care by my provider or a representative(s) for medical education or research. If any of these photographs are published in professional journals or used for any other educational purpose, which my provider may deem appropriate, I understand that I will not be identified or compensated in connection with the use or publication of these photographs. I understand that all slides and photographs are property of Brown Dermatology, Inc. _____**(Initial)**

Consent

Brown Dermatology, Inc. has my permission to call my Preferred Phone Number to confirm appointments and may leave messages pertaining to my visits on my answering machine/voicemail or with the person answering the phone. ☐ **Yes** ☐ **No**

The Practice will not disclose patient information to anyone other than the people listed below.

****** If no names are given, no patient information will be discussed with anyone other than the patient.******

Name: _____ ***Relationhip:*** _____

Contact Phone Number: _____

First Visit

A COMPLETE YET DISCREET EXAMINATION OF THE ENTIRE SKIN SURFACE is strongly suggested on your first visit and after a prolonged (years) absence. We often find clues from areas of the skin other than your major concern that can help us care for you better.

Yes, I would like a medical assistant present during my visit _____ **(Initial)**

No, I do not require a medical assistant present during my visit _____ **(Initial)**

Print Patient Name: _____Date:_____

Signature of Patient or ResponsibleParty:_____

Responsible Party Address :_____

_____ _____

Relationship* **Print Representative Name***

***As the representative of the above individual, I acknowledge receipt of the Notice on his/her behalf.**

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Financial Policy and Patient Responsibilities

PATIENT NAME:_____ DOB: _____

Thank you for choosing Brown Dermatology, Inc. as your medical provider. The following is a statement of our Financial Policy and Patient Responsibilities, which we require you to read and sign prior to receiving any services.

Insurance

Our practice participates with most health insurance plans. Insurances vary in their coverage and it is the patient's responsibility to understand his/her medical benefits. Please bring your insurance card and a photo I.D. with you at the time of your appointment, it will be copied and the information entered into our system. This is to ensure that the information we have is correct and that your insurance plan is current. If there are any issues concerning eligibility, coverage policies, or other problems not related to our billing practice, you will be responsible for all charges incurred

Insurance Referrals

You are responsible for all referrals required to comply with your insurance plan. Please obtain your Primary Care Physician's referral prior to your appointment if required by your insurance carrier. If your claims are denied for lack of referral or if the referral is rejected by your insurance company, you are responsible for all charges.

Co-Pays, Deductibles, Co-Insurance, & Self-Pays

All office co-pays, deductibles, co-insurance, and self-pay visits are to be paid at the time of service. Please check with your insurance company to determine the amount of your plan deductible. We accept cash, check, Visa and MasterCard. A $15.00 fee may be applied if the co-pay is not paid at the time of service. If you are unable to pay your balance in full, we will gladly arrange a payment plan. Arrangements must be made with our Billing Department prior to your appointment.

The following fees will not be filed with your insurance carrier; they are the direct responsibility of the patient:

No-Show Fee

Any patient who does not show for their scheduled appointment and has not called with 24 hour notice to cancel the visit may receive a $35 "no show" charge. Payment is due upon receipt of statement and no further appointments may be made until the charge has been paid.

Returned Check Fee

There is a $30 returned check fee.

I have read, understand, and agree to the financial policies as outlined

Your signature below indicates that you understand and acknowledge the financial responsibility for services rendered by Brown Dermatology, Inc. Further, your signature authorizes Brown Dermatology to release such medical information necessary to process your insurance claims.

Print Patient Name:_____ Date:_____

Signature of Patient or Responsible Party: _____