Comprehensive Dermatology Group
PEDIATRIC & ADULT SPECIALISTS

PEDIATRIC PATIENT INFORMATION

781 Garden View Ct, Suite 201, Encinitas, CA 92024
Phone 760 634 3376 Fax 760 634 7955

PLEASE PRINT AND COMPLETE BOTH SIDES

Date: _____

Legal Patient Name: _____
Title Last First MI

Nickname: _____ **Siblings:** _____
(Name and ages)

DOB: _____/_____/_____ **Age:** _____ **Male:** _____ **Female:** _____

Transgender: Male/man (FTM) Female/woman (MTF) Nonbinary Prefer not to say/other

Parent/Legal Guardian Name: _____ _____
(Mother) (Father)

Mother DOB: _____/_____/_____ **Father DOB:** _____/_____/_____

Patient's Parents (check one) ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Deceased**

Parent/Legal Guardian Employer/Occupation: _____ _____
(Mother) (Father)

Mailing Address: _____
City State Zip

Phone: (_____) _____ (_____) _____ (_____) _____
Home Cell Work

Best place to leave message, including confidential information: (_____) _____

Email: _____

INSURANCE INFORMATION

Primary Insurance Co: _____

Name of Subscriber: _____

Your relationship to insured: **Self** **Spouse** **Parent**

Member ID #: _____ **Group #:** _____

PLEASE COMPLETE FRONT AND BACK

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EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to patient: _____

Phone: (_____) _____ (_____) _____ (_____) _____
Home Cell Work

REFERRAL INFORMATION

Name of physician or friend that referred you: _____

Referring physician phone number: (_____) _____

Primary Care Physician: _____

Primary Care phone number: (_____) _____

PHARMACY INFORMATION

Name of Pharmacy: _____

Pharmacy Address: _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. **Not all services are covered by all contracts.** We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received payment from your insurance carrier. If we do not participate in your insurance plan, you may still choose to be seen in our practice as a "SELF PAY" patient and the payments will be due at time of service.

SUNSHINE ACT

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Parent/Legal Guardian Signature: _____ Date: _____

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Medical History

Patient Name _____ **D.O.B** _____

Did someone refer you to us? (NAME) _____

What is your child's main skin concern today? _____

How long has it been present? _____

Treatment to date: _____

_____ Did it help? _____

Any other skin problems that need to be addressed today? _____

_____

Dry/sensitive skin? ☐ Yes ☐ No Eczema? ☐ Yes ☐ No

Asthma? ☐ Yes ☐ No Hay fever? ☐ Yes ☐ No

Past Medical History: Birth History ☐ Natural ☐ C-Section Weight ___ lbs ___ oz

Any health problems? _____

Prior surgeries or hospitalizations? _____

_____

Please List Current/Other Medications: _____

_____

Adverse Reactions: (Drug, herbal)? _____

Allergies (foods/other)? _____

Are your child's immunizations up to date? ☐ Yes ☐ No

Covid 19 Vaccination? ☐ Yes ☐ No If yes, date: _____

MEDICAL PROBLEMS & SYSTEM REVIEW Child	No	Yes
Weight Loss		
Recent Fever		
Eyes		
Skin cancer / melanoma		
Headaches		
Epilepsy / Seizure Disorder		
Psychiatric Problems		
Ear / Nose / Throat		
Heart Problems		
Breathing difficulties		
Stomach pain, vomiting, diarrhea		
Muscle aches / weakness		
Bladder problems		
Endocrine Problems		
Other:		

FAMILY HISTORY
(Please indicate relationship to your child for yes responses)

Condition/illness	No	Yes	Relationship
Skin Cancer:			
Melanoma:			
Eczema:			
Asthma:			
Allergic Rhinitis:			
Other:			

SOCIAL HISTORY:

Siblings/Name/Age:

Is there anything else you would like to share with us about your child's history?

Is it OK to offer lollipop to your child? ☐ Yes ☐ No

Reviewed by _____ Date _____

PLEASE COMPLETE FRONT AND BACK

Office Policy

1. **Missed Appointments**:

   - We require at least 24 business hours if you need to reschedule or cancel a regular appointment. A $50 charge will be applied for appointments that are not cancelled in this time frame.
   - We require at least 48 business hours if you need to reschedule or cancel a surgical procedure. A $100 charge ($250 charge for Mohs surgery) will be applied for surgical no shows or reschedules under the 48-business hour window.
   - Dr. Gigler's missed appointment fees are $100 for 15-minute regular office visits, $150 for any 30-minute procedures/visits and $250 for Mohs surgery.
   - Please **Do Not** rely on our automated reminder service as your only reminder to keep your scheduled appointment, as we cannot guarantee this service or that the phone number provided is accurate and functional for this purpose.
   - Please **Do Not** reply on text reminders. You must call our office to cancel your appointment.

2. **Co-Payments and Deductibles**:
   - Co-pays are due at the time of check-in for your appointment. Our office accepts credit (Visa – Master Cards) and debit cards only. We do not accept cash or checks.

3. **Insurance Cards**:
   - Please provide us with your insurance card. If you are unable to provide your insurance card, we will gladly see you as a **"Self-Pay Patient".** Then, you may submit the claim to your insurance for reimbursement.

4. **Insurance Policies**:
   - As a courtesy, we will bill your primary and secondary insurance companies. However, patients are responsible to call their insurance to make sure Comprehensive Dermatology Group is in network with their plan and to check what services are/are not covered by their insurance plan. You are ultimately responsible for payment of services not covered by your insurance plan.

5. **Cosmetic Services**:
   - Cosmetic services must be paid at the time of your visit. These services cannot be billed to your insurance. Cosmetic services include, but are not limited to: skin tag removal, benign growth removal, Botox, filler, peels, and laser treatments.

6. **Minor Patients:**
   - The adult accompanying a minor and the minor's parents or guardians are responsible for full payment for services rendered. Comprehensive Dermatology Group is **NOT** a party to any divorce decree. Financial responsibility for minor receiving medical services rests with accompanying adult.

7. **Balances Due:**
   - Comprehensive Dermatology Group will send you a statement after your insurer have been billed. If you have not received one 30 days after your visit, please contact our office. Once you receive the statement, you have 30 days from the date on the statement to dispute or pay the charges. We will charge a late fee on all outstanding balances after 30 days. If no payment is received after 120 days, your account may be turned to a collection agency.
   - If your account is sent to collections, you understand and agree that you will be responsible for paying the outstanding balance in full, including any additional fees or costs incurred due to the collection process like collections fees, interest on overdue balances, legal fees (if applicable).

By signing below, you agree that you received, understand and will abide by the described office policy: Thank you.

Print Name

Signature

Date

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Patient Name: _____ DOB: _____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Under HIPPA requirements, we are not allowed to give any of your child's health information to anyone other than the parent and/or legal guardian who has signed the Pediatric Patient Forms. Please sign below if you wish to have us leave or discuss information regarding your child's appointment, test results, or procedures with another member of your family. Signing this form will only allow us to discuss appointment, test results, and procedures with the persons listed below.

I authorize Comprehensive Dermatology Group to release appointment information, test results, and procedure information to the following individuals.

1. _____ Relation to patient: _____
2. _____Relation to patient: _____

Parent/Legal Guardian Signature: _____Date:_____

AUTHORIZATION TO LEAVE A MESSAGE ON ANSWERING MACHINE

Under HIPPA requirements, we are not allowed to give any of your child's health information to anyone other than the parent and/or legal guardian who has signed the Pediatric Patient Forms. Please sign below if you wish to have us leave information regarding your child's appointment, test results, or procedures on a voicemail or answering machine. Signing this form will only allow us to leave appointment, test results, and procedures information on the phone numbers listed below.

I authorize Comprehensive Dermatology Group to leave a message regarding appointment information, test results, and procedure information on the following answering machines/voicemails.

1. (_____)_____
2. (_____)_____
3. (_____)_____

Parent/Legal Guardian Signature:_____ Date_____

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A copy of the Notice of Privacy Practices (HIPPA) is available upon request; please ask one of the front office staff. We also have the current notice posted on our website at comprehensivederm.com.

I, _____ hereby, acknowledge receipts of the Notice of Privacy Practices and photo consent given to me.

Sign: _____ Date: _____

If not signed, reason why acknowledgement was not obtained: