Hackensack Meridian *Health*
Joseph M. Sanzari Children's Hospital

155 Polifly Road, Suite 101
Hackensack, New Jersey 07601
P: 551.996.8697 F: 201.441.9963

WE ARE LOCATED AT:

155 Polifly Road, Suite 101
Hackensack, New Jersey 07601
551.996.8697

Driving Instructions are on page 6

Dear Patient & Family:

Thank you for choosing Hackensack University Medical Center as your healthcare provider. Our intention is to provide you and your family with excellent care. Our center is designed for children and their families. Our physicians, nurses and staff are specifically educated to provide that exceptional level of care. In addition, our administrative staff is here to help you with any scheduling, billing and other non-clinical issues. Please review the following information.

Appointment:

We kindly request that you arrive 15 minutes prior to your scheduled appointment in order for us to complete the registration process. A legal guardian *must* accompany all children under the age of 18 in order to be seen by the physician.

If, for any reason, you are unable to keep your scheduled appointment, please contact our office at **(551) 996-8697 at least *24 hours in advance* to avoid a cancellation fee of $25** before you may reschedule your appointment.

Insurance/payment Policy:

The day of your appointment, we ask that you bring:

1. ***Patient's insurance card***
2. ***Valid Photo Identification***
3. ***Prescription or attached form (page 2) requesting a pediatric dermatology consultation signed by your pediatrician***
4. ***Referral (if required by your health insurance company)***
5. ***Pertinent medical records (i.e. lab results, medication list)***

If we are a participating provider with your insurance carrier, we will gladly bill your insurance company on your behalf, up to (2) insurance carriers. You will be responsible for any out of pocket expenses such as specialist co-pays and deductibles, or for any services being rendered that are not covered under your plan.

If we do not participate with your insurance carrier, payment is expected in full, at the time of service unless prior arrangements have been made. Our office staff will provide you with a form which you may submit to your insurance carrier individually for reimbursement.

Our goal is to provide you with the best quality, state of the art medical care, in an environment that is sensitive to your needs. Please let us know how we are doing or how we can improve our service, and please do not hesitate to call us if you have any questions.

Thank you for choosing our practice.

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For your doctor to sign and fax back to 201-441-9963

This form, or a prescription from your doctor requesting a pediatric dermatology consultation, *is required for the initial visit*

This form is does not replace a referral
should one be required by your insurance company.

REQUEST FOR SPECIALIST CONSULTATION

PEDIATRIC DERMATOLOGY

Patient Name: _____

Date of Birth: _____

Reason for Consultation:

_____

_____

Physician Requesting Consultation: _____

NPI #: _____

Address: _____

_____

Phone: _____ Fax: _____

_____ _____
Physician signature Date

***Please sign and fax back to 201-441-9963**

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Child's Name_____ **Date of birth** _____
First Last

Age: _____ **months/years** Gender: Male Female

Address: _____

City, State, Zip: _____

Parent/Guardian Information:

Parent/Guardian 1:_____ *Parent/Guardian 2*: _____

Occupation: _____ Occupation: _____

Marital status: ☐single ☐married ☐divorced ☐widowed ☐single ☐married ☐divorced ☐widowed

Date of Birth: _____ Date of Birth: _____

Address: ☐ Same as above _____ Address: ☐ Same as above _____

City, St., Zip_____ City, St., Zip_____

Please check preferred contact number and/or email address:

☐Home: _____ ☐Home: _____

☐Work: _____ ☐Work: _____

☐Cell: _____ ☐Cell: _____

☐Email: _____ ☐Email: _____

Is it okay to leave a voicemail that may contain personal health information at this number? Yes No

Responsible Party (Guarantor) Name: _____ **Relation to patient:** _____

Employer: _____

Employer address: _____

Language(s) spoken: _____ **Do you need an interpreter?** Yes No

Race: _____ **Ethnicity:** _____

PEDIATRICIAN: _____ Phone: _____

Address: _____

Referring Physician: ☐ Check here for pediatrician listed above

Name: _____ Phone: _____

Address: _____

Primary Insurance Coverage:

Company: _____

Claims Mailing Address: _____

_____

Phone: _____

Policy#: _____

Group#: _____

Effective date: _____

Name of Insured: _____

Relationship to patient: _____

Insured's birthdate: _____

Insured's employer: _____

Employer address: _____

_____

Secondary/Supplemental Insurance Coverage:

Company: _____

Claims Mailing Address: _____

_____

Phone: _____

Policy#:_____

Group#:_____

Effective date: _____

Name of Insured: _____

Relationship to patient: _____

Insured's birthdate: _____

Insured's employer: _____

Employer address: _____

_____

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Child's Name_____ **Date of birth** _____
First Last

What is the reason for your child's visit today? _____

_____

Any associated symptoms (please check): ☐Itching ☐Bleeding ☐Difficulty sleeping ☐ Pain

For associated pain, where is it painful? _____

Severity of pain (please circle)? 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS
(For each system, please CIRCLE any/all that apply within PAST MONTH or NONE if applicable):

Constitutional: Fever Chills Feeling Poorly Feeling Tired Recent Weight Gain Recent Weight Loss	**NONE**
Eyes: Eye Pain Red Eyes Itchy Eyes Discharge from Eyes Eyesight Problems Dry Eyes	**NONE**
ENT: Ear Ache Loss of Hearing Nosebleeds Nasal Discharge Sore Throat Hoarseness	**NONE**
Cardiovascular: Chest Pain Palpitations Fast Heart Rate Slow Heart Rate Leg Claudication Leg Swelling	**NONE**
Respiratory: Shortness of Breath Wheezing Cough Trouble Breathing with Exertion or When Flat	**NONE**
Gastrointestinal: Nausea Vomiting Diarrhea Constipation Heartburn Blood in Stool Abdominal Pain	**NONE**
Genitourinary: Pain with Urination Trouble Urinating Genital Discharge Abnormal Vaginal Bleeding	**NONE**
Musculoskeletal: Joint Pain Joint Stiffness Joint Swelling Limb Pain Limb Swelling	**NONE**
Integumentary: Skin Lesions Skin Wound Itching Change in a Mole Breast Pain Breast Lump	**NONE**
Neurological: Confusion Convulsions Dizziness Fainting Limb Weakness Difficulty Walking	**NONE**
Psychiatric: Suicidal Sleep Disturbance Anxiety Depression Change in Personality Emotional Problems	**NONE**
Endocrine: Muscle Weakness Feelings of Weakness Hot Flashes Deepening of the Voice	**NONE**
Heme/Lymph: Easy Bruising Easy Bleeding Swollen Glands	**NONE**

Other (Please Explain): _____

ALLERGIES:

Does your child have any allergies to medications: Yes (please list medication and reaction - hives, rash, anaphylaxis) No

_____

_____

Allergies to foods: yes no (If yes, please circle/list) dairy soy eggs wheat peanuts tree nuts fish shellfish

Other foods: _____

Allergies to environment: tree grass pollen animal (cat dog hamster) dander dust mites

_____

Has your child been tested for allergies? ☐ Scratch testing ☐ Bloodwork ☐ Patch testing for contact allergens

If yes, please provide us with the results, if not available, who performed the testing? _____

_____

Is your child allergic to latex? Yes No

MEDICATIONS: Please check/list ALL of your child's current medications/vitamins/herbal supplements below

☐ Multi-vitamin ☐ Fluoride ☐ vitamin D ☐ Benadryl (diphenhydramine) ☐ Atarax (hydroxyzine)

☐ Zyrtec (cetirizine) ☐Claritin (loratidine) ☐Tylenol (acetaminophen) ☐Motrin (ibuprofen)

_____

_____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____

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BIRTH HISTORY:
How many weeks gestation at birth? _____ Birth weight _____Multiple birth: no twin triplet

Complications with pregnancy/delivery: Yes No _____

MEDICAL HISTORY:
Has your child ever had (diagnosed/treated) for any of the following?:

Skin conditions *(please circle)*: Acne Alopecia (hair loss) Burn Cysts Eczema/Atopic Dermatitis Psoriasis

Skin infections: Molluscum Warts Impetigo Folliculitis Abscess MRSA Herpes/cold sores Varicella Fungal

Birthmarks (please circle): Moles Infantile hemangioma Port Wine Stain Nevus sebaceous

Skin (other): Other: _____

Please circle

Anemia: Yes No _____
Asthma/Breathing: Yes No _____
Arthritis: Yes No _____
Bleeding Tendency: Yes No _____
Bowel Problems: Yes No _____
Cancer/Leukemia: Yes No _____
Developmental Disorder: Yes No _____
Endocrine: Yes No Diabetes Thyroid Growth disorder _____
Ear/Nose/Throat (ENT): Yes No _____
Eye Disorder: Yes No _____
Heart Disorder/Defect: Yes No _____
High Blood Pressure/Cholesterol: Yes No _____
Immune Deficiency: Yes No _____
Kidney/Urinary: Yes No _____
Liver Disease: Yes No _____
Seizure/Neurological: Yes No _____
Psychiatric/Emotional/Behavioral: Yes No _____
Any Other _____

SURGICAL HISTORY: ☐ Appendectomy ☐ Tonsillectomy ☐ Adenoidectomy ☐Hernia repair ☐ Mole removal

Other (please list approximate dates): _____

FAMILY HISTORY: Does your child have family members with a history of major illness or conditions? List below:

	Please circle	**Relationship to Patient (please specify maternal or paternal side)**
Acne, scarring	Yes No	_____
Atopic Dermatitis (Eczema):	Yes No	_____
Seasonal allergies (hay fever):	Yes No	_____
Allergies (medications, foods):	Yes No	_____
Psoriasis:	Yes No	_____
Skin infection (impetigo, HSV, fungal)	Yes No	_____
Skin Cancer (basal/squamous cell):	Yes No	_____
Moles - atypical/dysplastic:	Yes No	_____
Melanoma	Yes No	_____
Scars - Hypertrophic/keloid	Yes No	_____
Asthma:	Yes No	_____
Inflammatory Bowel Disease	Yes No	_____
Celiac disease:	Yes No	_____

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Child's Name_____ **Date of birth** _____
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FAMILY HISTORY (continued):

Autoimmune (lupus): Yes No _____
Thyroid disease: Yes No _____
Cancer (i.e. lung, breast, colon): Yes No _____
Genetic disease: Yes No _____
Psychiatric disease: Yes No _____
Vascular birthmarks: Yes No _____

SOCIAL HISTORY:

Does your child, or anyone living in your home, smoke? Yes No

Do you have pets in your home? Yes No If Yes, what types? _____

Do you have other children? Yes No If Yes, how many? _____What are their ages? _____

For female patients, if applicable:

Age at first menses? _____ Last menstrual period? _____ Are menses regular? Yes No

Has the patient ever been pregnant? Yes No

Is the patient pregnant or planning on becoming pregnant during treatment? Yes No

I hereby authorize Dr. Emily Berger/ Dr. Lauren Keller/ Dr. Julie Schaffer/ Dr. Helen Shin to examine

_____ and treat him/her as necessary. I understand that this is not a
(patient's name)

complete physical examination.

_____ _____
Parent/Guardian Signature Date

DRIVING INSTRUCTIONS

FROM THE GEORGE WASHINGTON BRIDGE

Follow Rt. 80 West, staying in the local lanes, to Exit 64B. Turn right at the light onto Polifly Rd. traveling north. Our building is less than ¼ mile on the left.

FROM PATERSON AREA AND WEST

Follow Rt. 80 East to Route 17 South, to Exit 64. Take Terrace Ave. /Polifly Rd. ramp. Make a left at the light onto Terrace Ave. which becomes Polifly Rd. Our building is ¼ mile on the left.

FROM SOUTHERN NEW JERSEY VIA NJ TURNPIKE

Follow Rt. 95-NJ Tpk. North to Rt. 80. Take 80 West towards Hackensack and Paterson. Staying in the local lanes, take Exit 64B. Make a right at the light onto Polifly Rd. Our building is less that ¼ mile on the left.

FROM NORTHWESTERN NEW JERSEY VIA RT 17

Follow Rt. 17 South to Terrace Ave/Polifly Rd. exit. Make a left at the light onto Terrace Ave. which becomes Polifly Rd. Our building is ¼ mile on the left.

FROM THE LINCOLN TUNNEL

Take Rt. 3 West to Rt. 17 North. Exit at Polifly Rd/I-80 East. Stay straight onto Polifly Rd. Our building is ¼ mile on the left.

FROM THE GARDEN STATE PARKWAY

Either North or South, take Rt. 80 East exit, follow to Route 17 South. Take Terrace Ave/Polifly Rd. exit and make a left at the light onto Terrace Ave. This will become Polifly Rd. and our building is ¼ mile on the left.