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.
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
<table>
<thead>
<tr>
<th><strong>Child’s Name</strong></th>
<th><strong>Date of birth</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Last</td>
</tr>
<tr>
<td>Age:</td>
<td>months/years</td>
</tr>
<tr>
<td>Gender:</td>
<td>Male</td>
</tr>
</tbody>
</table>

**Address:**

City, State, Zip:

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**Parent/Guardian Information:**

**Parent/Guardian 1:**

Occupation: _________________________

Marital status: [ ] single [ ] married [ ] divorced [ ] widowed

Date of Birth: _________________________

Address: ___________________________

City, St., Zip: _______________________

Please check preferred contact number and/or email address:

[ ] Home: ___________________________

[ ] Work: ___________________________

[ ] Cell: ___________________________

[ ] Email: ___________________________

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

**Parent/Guardian 2:**

Occupation: _________________________

Marital status: [ ] single [ ] married [ ] divorced [ ] widowed

Date of Birth: _________________________

Address: ___________________________

City, St., Zip: _______________________

Please check preferred contact number and/or email address:

[ ] Home: ___________________________

[ ] Work: ___________________________

[ ] Cell: ___________________________

[ ] Email: ___________________________

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**Responsibility Party (Guarantor) Name:**

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: ___________________________

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**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: ___________________________

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**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: ___________________________
Child’s Name________________________________________  Date of birth _____________________

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

Eyes: Eye Pain  Red Eyes  Itchy Eyes  Discharge from Eyes  Eyesight Problems  Dry Eyes

ENT: Ear Ache  Loss of Hearing  Nosebleeds  Nasal Discharge  Sore Throat  Hoarseness

Cardiovascular: Chest Pain  Palpitations  Fast Heart Rate  Slow Heart Rate  Leg Claudication  Leg Swelling

Respiratory: Shortness of Breath  Wheezing  Cough  Breathing with Exertion  or When Flat

Gastrointestinal: Nausea  Vomiting  Diarrhea  Constipation  Heartburn  Blood in Stool

Genitourinary: Pain with Urination  Trouble Urinating  Genital Discharge  Abnormal Vaginal Bleeding

Musculoskeletal: Joint Pain  Joint Stiffness  Joint Swelling  Limb Pain  Limb Swelling

Integumentary: Skin Lesions  Skin Wound  Itching  Change in a Mole  Breast Pain  Breast Lump

Neurological: Confusion  Convulsions  Dizziness  Fainting  Limb Weakness  Difficulty Walking

Psychiatric: Suicidal Sleep Disturbance  Anxiety  Depression  Change in Personality  Emotional Problems

Endocrine: Muscle Weakness  Feelings of Weakness  Hot Flashes  Deepening of the Voice

Heme/Lymph: Easy Bruising  Easy Bleeding  Swollen Glands

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: ________________________________________________
Child’s Name ___________________________ Date of birth ___________________________

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

Hackensack Meridian Health Network June 2017
Child’s Name ____________________________ Date of birth __________________

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 ___________ 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.