Children's Dermatology Services

Main Office:
11279 Perry Highway
Pine Center, Suite 108
Wexford, PA 15090

South Fayette Satellite Office:
Children's South
205 Millers Run Road, 3rd Floor
Bridgeville, PA 15017

Monroeville Satellite Office:
Children's East
Building 1, Suite 110
4055 Monroeville Blvd
Monroeville, PA 15146

Telephone (724) 933-9190
Fax (724) 933-9194
www.chp.edu/CHP/dermatology

Welcome to our practice!

Please partner with us by supporting the following Patient Visit and Treatment Policies which will help us to provide the best care for your child.

1. **Appointment Times/Visit** - Arrive 15 minutes in advance of your child's scheduled appointment time and **allow about an hour for the visit**. Parents/patients who arrive 15 minutes later that their scheduled appointment time may need to reschedule. Generally our providers run on time and will do their best to see your child in a thorough but timely manner.

2. **Prescription Refills** – **Prescription refill requests will be considered only for those patients examined in the past six months or for those patients who are seen within the recommended follow up visit time, with the exception of patients on medications who need to be closely monitored.** If your child has not been seen within these timeframes, call our office to schedule a return appointment. Prescription refills called in after 3:00 pm will be processed, upon physician approval, the next business day.

3. **Treatment of Minors** – The State of Pennsylvania requires all patients under 18-years-of-age to be accompanied by a parent or legal guardian unless you, the parent or legal guardian, provide prior written consent for someone at least 18 years or older to accompany your child to the appointment and examination. Our check-in staff can provide you with a **Medical Consent Authorization Form** to permit someone other than the parent/guardian to be part of your child's visit. **Note**: Procedures will be performed **only** when a parent or legal guardian accompanies the child (under 18 years-of-age) at the time of the visit. Also, the initiation of Accutane will occur **only** when the parent is present with the child (under 18 years-of-age) for the start-up visit.

4. **Schedules** – We have several different providers whose schedules run simultaneously. While sitting in our waiting room, you may see a patient/parent who arrived after you getting called to an exam room before you do if they are seeing a different provider.

5. **Insurance Cards** – Our check-in staff must scan your insurance card at each visit.

6. **Number of Dermatology Conditions Treated Per Visit**– We strive to provide your child with exceptional patient care. In order to do this, we are happy to treat your child for up to **two** dermatologic conditions per visit.

Appointment Cancellation and No Show's – Please call our office at least 48 hours in advance should you need to cancel or reschedule your child's appointment. We have **a No-Show Policy** which states that failure to cancel an appointment within 24 hours or sooner to the appointment is considered a "no show". After three no show appointments per family, that family is dismissed from our practice.

Please see our one of our front desk team members if you have any questions. ***Thank you.***

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Children's Dermatology Services and Acne Treatment Center

Main Office:
11279 Perry Highway
Pine Center, Suite 108
Wexford, PA 15090

South Fayette Satellite:
Children's South
205 Millers Run Road, 3rd Floor
Bridgeville, PA 15107

Monroeville Satellite:
Children's East
Building 1, Suite 110
4055 Monroeville Blvd
Monroeville, PA 15146

Telephone: 724.933.9190
Fax: 724.933.9194

PATIENT INFORMATION FORM

Patient Name: ______________________________

Date of Birth: ____________ Sex: Female / Male Patient Age: ____________

Name of adult accompanying patient at today's visit: ______________________________

Legal relationship of adult to patient being seen? ______________________________

Is there a legal custody agreement in place for this patient?____________

****If so, please provide us with any relevant paperwork.****

Reason (s) for today's visit: ☐ Acne ☐ Warts ☐ Molluscum ☐ Eczema ☐ Birthmark ☐ Mole Check/ Removal ☐ Unknown Rash ☐ Hair Trouble ☐ Bleeding Lesion

Other: ______________________________

List all your child's past and existing medical problems:

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________

List all of your child's current medications;
including all oral, topical, and over-the-counter products:

1) ____________ 2) ____________ 3) ____________
4) ____________ 5) ____________ 6) ____________

List all of your child's medication allergies: (Please list the patient's rection to these allergies)

1) ____________ 2) ____________ 3) ____________
4) ____________ 5) ____________ Other: ____________

FAMILY HISTORY

Has anyone in your family ever been diagnosed with any of these conditions? Please list family member:

1. Melanoma:____
2. Basal Cell Carcinoma: ____
3. Squamous Cell Carcinoma: ____
4. Eczema: ____
5. Psoriasis: ____
6. Severe Acne: ____
7. Vitiligo: ____
8. Thyroid Problems: ____
9. Hair Loss/Alopecia: ____
10. Depression: ____
11. Lupus: ____
12. Crohn's Disease: ____

I verify that the above information is accurate:

Parent/Legal Guardian Signature: ______________________ **Todays Date:** / /

I reviewed and transferred this information into this patient's Epicare record. Name: ______________________

Print/Sign Date

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NEW PATIENT REGISTRATION FORM
Please complete ENTIRE form

Telephone: 724-933-9190
Fax: 724-933-9194

Patient's Information				
Last Name	First Name	MI	D.O.B. ____/____/___	Gender M or F
Language Race	Patient resides with (please circle below): Mother Father Both Other (Please Indicate)			

Pediatrician /PCP			
Physician's Name	Office/ Practice Name	Telephone Number	
Street Address	City	State	Zip

#1 Guardian/ Parent	☐ Check here if this person is the insurance carrier				
Last Name	First Name	MI		Relationship	SS# ______--______--_______
Street Address	City	State	Zip	E-mail Address	
Home Phone	Cell Phone	Work Phone		Employer	D.O.B. ____/____/____

#2 Guardian/ Parent	☐ Check here is if this person is the insurance carrier				
Last Name	First Name	MI		Relationship	SS# ______--______--_______
Street Address	City	State	Zip	E-mail Address	
Home Phone	Cell Phone	Work Phone		Employer	D.O.B. ____/____/____

Emergency Contact	
Name:	Relationship to patient:
Home Phone	Cell Phone

PAYMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION:
I authorize the release of my medical information necessary to process insurance claims
and request payment of insurance to Children's Community Pediatrics.

Signature: **Date:**

UPDATE: 11/8/2010

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