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.
Child’s Name: ___________________________ Date of birth: ___________________________

Age: ___________________ months/years

Gender: Male Female

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: ___________________________. Secondary/Supplemental Insurance Coverage: ___________________________.

Company: ___________________________. Company: ___________________________.

Claims Mailing Address: ___________________________. Claims Mailing Address: ___________________________.

Phone: ___________________________. Phone: ___________________________.

Policy#: ___________________________. Policy#: ___________________________.

Group#: ___________________________. Group#: ___________________________.

Effective date: ___________________________. Effective date: ___________________________.

Name of Insured: ___________________________. Name of Insured: ___________________________.

Relationship to patient: ___________________________. Relationship to patient: ___________________________.

Insured’s birthdate: ___________________________. Insured’s birthdate: ___________________________.

Insured’s employer: ___________________________. Insured’s employer: ___________________________.

Employer Address: ___________________________. Employer address: ___________________________.

__ of 5
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 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: ______________________________________________________________
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 ________________________________
Scar - Hypertrophic/keloid Yes No ________________________________
Asthma: Yes No ________________________________
Inflammatory Bowel Disease Yes No ________________________________
Celiac disease: Yes No ________________________________
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. Julie Schaffer/ Dr. Helen Shin to examine
__________________________________________ and treat him/her as necessary.

(patient’s name)

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 PATERNIA 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 TUNPIKE
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 than 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.