

**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: \_\_\_\_\_ First **months/years** Last 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: \_\_\_\_\_



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:** \_\_\_\_\_



**Child's Name** \_\_\_\_\_ **Date of birth** \_\_\_\_\_  
First Last

**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:

	<small>Please circle</small>	<b>Relationship to Patient (please specify maternal or paternal side)</b>
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	_____



**Child's Name** \_\_\_\_\_ **Date of birth** \_\_\_\_\_  
First Last

**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 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 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.