PEDIATRIC ASSOCIATES OF MADISON

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Robbie F. Dudley, M.D. Charlotte M. Meadows, M.D. Cynthia Dill, M.D. Jessica Magnusson, M.D. Elizabeth M. Bryant, M.D. Keri Read, M.D.

Date: _____ **PATIENT REGISTRATION** **Chart #_____**

PLEASE PRINT – FILL OUT ALL AREAS

PATIENT INFORMATION

CHILD'S NAME(OLDEST TO YOUNGEST) BIRTHDATE SSN SEX CELL PHONE# (14 YRS & OLDER)

1._____

Race: □ Asian □ African American □ White Other: _____ **Ethnicity:** □ Hispanic □ Non-Hispanic

2._____

Race: □ Asian □ African American □ White Other: _____ **Ethnicity:** □ Hispanic □ Non-Hispanic

3._____

Race: □ Asian □ African American □ White Other: _____ **Ethnicity:** □ Hispanic □ Non-Hispanic

4._____

Race: □ Asian □ African American □ White Other:_____ **Ethnicity:** □ Hispanic □ Non-Hispanic

PATIENT ADDRESS

_____

STREET CITY, STATE ZIP CODE

***PRIMARY CONTACT AND APPOINTMENT REMINDER PHONE # _____**

PARENT INFORMATION

***CELL PHONE CARRIER _____**

_____

DAD'S NAME DAD □ STEP DAD □

_____

ADDRESS

_____

DAD'S CELL PHONE #

_____

DOB SOCIAL SECURITY #

_____

EMPLOYER

_____

WORK PHONE NUMBER

_____

E-MAIL ADDRESS - May we add you to our email list? ___yes ___no

_____

MOM'S NAME MOM □ STEP MOM □

_____

ADDRESS

_____

MOM'S CELL PHONE #

_____

DOB SOCIAL SECURITY #

_____

EMPLOYER

_____

WORK PHONE NUMBER

_____

E-MAIL ADDRESS - May we add you to our email list? ___yes ___no

EMERGENCY CONTACT (FRIEND OR RELATIVE)

_____

NAME RELATIONSHIP HOME PHONE CELL PHONE

REFERRED BY: _____

CONTINUE ON BACK >>>>>>>>>

INSURANCE INFORMATION

PRIMARY INSURANCE

POLICY HOLDER'S NAME | DOB | SSN | COPAY

PRIMARY INSURANCE CO. | POLICY NUMBER | GROUP NUMBER

SECONDARY INSURANCE

POLICY HOLDER'S NAME | DOB | SSN | COPAY

SECONDARY INSURANCE CO. | POLICY NUMBER | GROUP NUMBER

PLEASE READ AND SIGN AUTHORIZATION AND ASSIGNMENT

*ALL COPAYS OR CO-INSURANCE ARE DUE AT THE TIME OF SERVICE.

I (We), the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me or members of my family for services rendered by this office. In the event of non-payment the account will accrue a monthly finance fee of $20 and may be turned over for collections and will result in dismissal from the practice.

I acknowledge and agree that Pediatric Associates of Madison, P.C., and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Pediatric Associates of Madison, P.C., if I have given up ownership or control of any such telephone number.

CONSENT FOR TREATMENT

I authorize the doctors of Pediatric Associates of Madison, P.C., to treat my minor children listed above as they deem medically necessary. I authorize emergency medical treatment for the above-named child(ren) in the event that he/she is brought into this practice by any person other than myself.

SIGNATURE OF PARENT OF LEGAL GUARDIAN | PRINT NAME | DATE