PEDIATRIC ASSOCIATES OF MADISON

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www.pedsofmadison.com

Robbie F. Dudley, M.D. Charlotte M. Meadows, M.D. Cynthia Dill, M.D. Jessica Magnusson, M.D
Elizabeth M. Bryant, M.D. Veronica Collier, M.D.

Date: _____________

PATIENT REGISTRATION

Chart #________________

PLEASE PRINT – FILL OUT ALL AREAS

PATIENT INFORMATION

CHILD'S NAME	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

FORMS/SERVICE FEES

FORMS

Fees will be charged for the following forms if not requested at the time of an office visit:

- Blue Card - $5
- Camp & Sports Physicals Forms - $10
- School Medication Authorization Forms - $5
- FMLA or Disability Forms - $15
- Letters requested by patients - $5

(ALL FORM FEES WILL BE DUE AT THE TIME OF PICKUP.)
Rush Form Fee:
If a form is needed in less than 24 hrs. the form fee will be doubled.

SERVICES

- Nurse/Lab visits which are non-physician visits - $15
  (Weight checks, immunization updates, allergy shots, and labs.)
- No-Show Appointments - $50
- Minimum $25 charge for any after-hours physician call not related to an office visit

PLEASE READ AND SIGN AUTHORIZATION AND ASSIGNMENT

*ALL COPAYS OR CO-INSURANCES 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, either by insurance or by me, the balance due will increase and will include a monthly 1.5% finance charge and may include attorney and/or collection fees. Collection proceedings may result in permanent dismissal.

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