PEDIATRIC ASSOCIATES OF MADISON
21 Hughes Rd., Suite 2 ● Madison, Alabama 35758 ● 256-772-2037 ● Fax 256-772-9523
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.

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, either by insurance or by me. The account may be turned over for collections and may 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

NOTIFICATION OF POSSIBLE NON-COVERED SERVICES

There are recommended screening tests which may be performed at a well checkup that are necessary for the maintenance of good health. These tests may or may not be covered by your medical insurance. If your medical insurance is Healthcare Reform Compliant it should cover the following services. It will be the patient's responsibility to pay for any non-covered services. If you have any questions about whether or not a particular service is covered by your medical insurance, please contact your insurance company.

_____

Chart Number

Possible Non-Covered Service(s)	**Amount**
Complete Blood Count (CBC)- every 2 years	$17.00
Cholesterol Screening – 9-11 years old	Sent to outside Lab
Eye Screening- with a spot vision screener	$20.00
Hearing Screen	$32.00
M-Chat Autism Questionnaire- 18 months old	$15.00
Glucose	$6.00
Urinalysis	$10.00

FORMS/SERVICE FEE

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

I (We), the undersigned have read and 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 account may be turned over for collections and may result in dismissal from the practice.

_____

Guardian Signature Date