Patient Profile

Patient Information

Name: _____ Gender: M / F

Name of hospital where your child was born _____

Date of Birth: _____ **Social Security #:** _____

Primary Language: __ English __ Spanish __ Other _____

Race: __ White __ African American __ Asian __ Multiracial

Religion: __ Christian __ Roman Catholic __ Baptist __ Refuse to Answer __ Other _____

Ethnic Group: __ Not Hispanic or Latino __ Hispanic or Latino __ Unknown

Smoking Status: __ Never Smoked __Former Smoker __ Current Smoker

Parent/Guardian Information

FATHER/OTHER	MOTHER/OTHER
Name:	Name:
Address:	Address:
City/ST/Zip:	City/ST/Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Social Security No.:	Social Security No.:
Date of Birth:	Date of Birth:
Employer:	Employer:
Email Address:	Email Address:

Insurance Information

- Please Note that you will be asked for your insurance card at every visit

Insurance Company _____ Insured ID # _____

Address _____ Policy Group # _____

Do you have secondary Insurance? Yes ___ No ___ If Yes, Insured Name: _____

Ins. Carrier Name: _____ ID# _____ Grp: _____

In the event that you are not able to bring (Child's name) _____ / (DOB) _____ to his/her appointment, please list below anyone 18 years of age or older that has permission to bring your child to his/her appointment, consent for medical care / treatment, and/or receive medical information.

Name: _____ Relationship to child _____

Name: _____ Relationship to child _____

Pharmacy Information

Pharmacy Name: _____ Phone No.: (_____) _____ - _____

City: _____

I give my permission to allow my Healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

➜ **(Please Initial)** _____

By initialing the consent form you are giving your healthcare provider permission to collect prescription information and are giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

Please Read and Sign:

I understand that I am responsible for any non-covered charges or any unpaid balances related to my insurance and I will be charged a 35% collection fee in the event my account is turned over to a collection agency. I also give Madison Pediatric Associates my permission to call me on my mobile phone regarding my or my child's medical needs or for billing issues. I further acknowledge the practice has provided me a copy of its notice of privacy practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

➜ ☆ **Parent / Guardian** _____ **Date** _____

Emergency Contact Information:

Name _____

Address _____ Phone # _____

Name _____

Address _____ Phone # _____