Madison Pediatric Associates

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

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

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: Work #:	Employer: Work #:
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 who has permission to bring your child to his/her appointment, consent for medical care/treatment, and/or receive medical attention.

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 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 primary 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 & 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 (Other than Parents):

Name: _____

Address: _____ Phone: _____

Name: _____

Address: _____ Phone: _____

Madison Pediatric Associates

Financial Policy
Madison Pediatric Associates

Thank you for choosing Madison Pediatric Associates, PSC as your primary care provider. The following is a statement of our Financial Policy, which we require you to sign prior to any treatment. All patients / parents must complete this form prior to seeing the Pediatrician.

We are committed to providing excellent medical care at a fair and reasonable price. Our staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We will make every effort to work with you to file insurance claims and timely resolve any outstanding balances.

INSURANCE: Insurance coverage is a contract between you and you insurance company. Each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered and not covered. If the insurance company has not processed and paid the claim within 90 days, then payment of the account will become the responsibility of the parent / legal guardian. In the event of a separation / divorce, the parent bringing the child for the appointment is responsible for payment.

DEMOGRAPHIC INFORMATION & INSURANCE CARDS: It is important that we have updated demographic data from both parents so that we will be able to contact you in the future. We must have a current copy of your insurance card on file at all times. If your insurance changes, it is your responsibility to let us know. If prior encounters need to be refiled to a different insurance, you must notify us immediately due to Timely Filing requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for timely filing by your insurance and those claims would become you financial responsibility.

NETWORK PROVIDERS: It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify if there is any question regarding network eligibility.

CO-PAYS, DEDUCTIBLES: I understand any co-pays are due from me at time of service. If not paid at time of service, a $25.00 fee will apply. I understand that I am responsible for the balance not covered by my insurance.

CANCELLATION OF APPOINTMENTS: As a courtesy to other patients and physicians, we require an advance notice prior to canceling appointments. There will be a $25.00 fee for failure to notify us in advance. After three no-show appointments, the patient will be released from the practice.

PAYMENT: We accept Cash, Check, MasterCard, Visa, and Debit Cards

ASSIGNMENT OF BENEFITS / AUTHORIZATION: As a parent or legal guardian, I authorize payment of medical benefits to be made directly to Madison Pediatric Associate for services rendered. I further agree to be fully responsible for all lawful debts incurred for services provided.

→ **Signature of Parent / Legal Guardian** **Date**

Madison Pediatric Associates

PATIENT PORTAL CONSENT FORM

PATIENT'S NAME _____ DOB _____

ACCEPT

I _____ **AGREE** to the terms of accessing my child's patient portal through Madison Pediatrics. I understand that Madison Pediatrics will email me a link that will provide access to my child's medical records under the circumstances that I have to create the account myself.

EMAIL: _____

→ **Signature of Parent / Legal Guardian** **Date**

DECLINE

I _____ have received all the information necessary to gain access to my child's patient portal, but at this time **I DECLINE**. I understand that if at any time I wish to gain access, all I have to do is ask and the information will be sent to me electronically to gain access.

→ **Signature of Parent / Legal Guardian** **Date**

Madison Pediatric Associates

Initial History Questionnaire

PATIENT NAME

PATIENT SOCIAL SECURITY NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐M ☐F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live now.

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

Birth History

Birth Weight: _____

Was the baby born at term?_____ Early?_____ Late?_____

If early, how many weeks gestation? _____

Did mother have any illness or problem with her pregnancy? ☐YES ☐NO

Explain: _____

During pregnancy, did mother

Smoke? ☐YES ☐NO Drink Alcohol? ☐YES ☐NO

Use drugs or medications? ☐YES ☐NO

What _____ When _____

Was the delivery ☐Vaginal ☐Cesarean

If Cesarean, why? _____

Did your baby have any problems right after birth? ☐YES ☐NO

Explain _____

Was initial feeding ☐Breast ☐Bottle

Did your baby go home with the mother from the hospital? ☐YES ☐NO

Explain _____

General

Do you consider your child to be in good health? ☐YES ☐NO Explain _____

Does your child have any serious illnesses or medical conditions? ☐YES ☐NO Explain _____

Has your child had any serious injuries or accidents? ☐YES ☐NO Explain _____

Has your child had any surgeries? ☐YES ☐NO Explain _____

Has your child ever been hospitalized? ☐YES ☐NO Explain _____

Is your child allergic to any medication or drugs? ☐YES ☐NO Explain _____

Does your child take any regular medications? ☐YES ☐NO Explain _____

Development

Are you concerned with your child's physical development? ☐YES ☐NO Explain _____

Are you concerned about your child's mental or emotional development? ☐YES ☐NO Explain _____

Are you concerned with your child's attention span? ☐YES ☐NO Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

General

Have any family members had the following:

Deafness	☐YES	☐NO	Who_____	Comments_____
Nasal Allergies	☐YES	☐NO	Who_____	Comments_____
Asthma	☐YES	☐NO	Who_____	Comments_____
Tuberculosis	☐YES	☐NO	Who_____	Comments_____
Heart Disease (before 50 years old)	☐YES	☐NO	Who_____	Comments_____
High Blood Pressure (before 50 years old)	☐YES	☐NO	Who_____	Comments_____
High Cholesterol	☐YES	☐NO	Who_____	Comments_____
Anemia	☐YES	☐NO	Who_____	Comments_____
Bleeding Disorder	☐YES	☐NO	Who_____	Comments_____
Liver Disease	☐YES	☐NO	Who_____	Comments_____
Kidney Disease	☐YES	☐NO	Who_____	Comments_____
Diabetes (before 50 years old)	☐YES	☐NO	Who_____	Comments_____
Bed-wetting (after 10 years old)	☐YES	☐NO	Who_____	Comments_____
Epilepsy or Convulsions	☐YES	☐NO	Who_____	Comments_____
Alcohol Abuse	☐YES	☐NO	Who_____	Comments_____
Drug Abuse	☐YES	☐NO	Who_____	Comments_____
Mental Illness	☐YES	☐NO	Who_____	Comments_____
Mental Retardation	☐YES	☐NO	Who_____	Comments_____
Immune Problems, HIV or AIDS	☐YES	☐NO	Who_____	Comments_____

Additional Family History _____

_____

_____

Past History

Does your child have or has he/she ever had:

Chickenpox	☐YES	☐NO	When _____
Frequent Ear Infections	☐YES	☐NO	Explain _____
Problems with Ears or Hearing	☐YES	☐NO	Explain _____
Nasal Allergies	☐YES	☐NO	Explain _____
Problems with Eyes or Vision	☐YES	☐NO	Explain _____
Asthma, Bronchitis, Bronchiolitis, or Pneumonia	☐YES	☐NO	Explain _____
Any Heart Problem or Heart Murmur	☐YES	☐NO	Explain _____
Anemia or Bleeding Problem	☐YES	☐NO	Explain _____
Blood Transfusion	☐YES	☐NO	Explain _____
Frequent Abdominal Pain	☐YES	☐NO	Explain _____
Constipation Requiring Doctor Visits	☐YES	☐NO	Explain _____
Bladder or Kidney Infection	☐YES	☐NO	Explain _____
Bed-wetting (after 5 years old)	☐YES	☐NO	Explain _____
FOR GIRLS - Has she started her Menstrual Periods?	☐YES	☐NO	Explain _____
FOR GIRLS - Are there problems with her periods?	☐YES	☐NO	Explain _____
Any chronic or recurrent skin problems (acne, eczema, etc.)	☐YES	☐NO	Explain _____
Frequent Headaches	☐YES	☐NO	Explain _____
Convulsions or other Neurological Problem	☐YES	☐NO	Explain _____
Diabetes	☐YES	☐NO	Explain _____
Thyroid or other Endocrine Problem	☐YES	☐NO	Explain _____
Any other significant problem	☐YES	☐NO	Explain _____
Use of Alcohol or Drugs	☐YES	☐NO	Explain _____