MADISON VALLEY PEDIATRICS, P.C.
101 WESTOVER CIRCLE SUITE A
MADISON, AL 35758
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PATIENT INFORMATION

DATE_____

PATIENT'S NAME_____DATE OF BIRTH __/__/__
(LAST) (FIRST) (MIDDLE)

ADDRESS_____
(STREET) (CITY) (STATE) (ZIP CODE)

PHONE ( ) _____PATIENT SSN____-___-____AGE_____SEX F___M___

FATHER'S NAME_____ FATHER'S SSN_____-_____-_____

FATHER'S DATE OF BIRTH_____OCUPATION_____

EMPLOYED BY_____WORK PHONE# ( ) _____

MOTHER'S NAME_____MOTHER'S SSN_____-_____-_____

MOTHER'S DATE OF BIRTH_____OCUPATION_____

EMPLOYED BY_____WORK PHONE# ( ) _____

EMERGENCY CONTACT NAME_____PHONE # _____

OTHER CHILDREN IN THE FAMILY:

NAME_____DATE OF BIRTH_____SSN____-___-____

NAME_____DATE OF BIRTH_____SSN____-___-____

NAME_____DATE OF BIRTH_____SSN____-___-____

INSURANCE COMPANY NAME_____EFFETIVE DATE_____

MAILING ADDRESS_____

POLICY/CONTRACT #_____GROUP# _____

MAILING ADDRESS_____

POLICY/CONTRACT #_____GROUP# _____

OUR POLICY IS FULL PAYMENT AT THE TIME SERVICES ARE RENDERED. NO ACCOUNT WILL BE CARRIED OVER 90 DAYS.

WE WILL FILE FOR ALL INSURANCES, AND FOR INPATIENT SERVICES OF ALL INSURANCES. ALSO I UNDERSTAND, I WILL BE RESPONSIBLE FOR NON-ALLOWED SERVICS THAT ARE NOT COVERED UNDER MY INSURANCE POLICY. I ALSO GIVE CONSENT FOR THE RELEASE OF ANY MEDICAL RECORDS TO MY INSURANCE COMPANY.

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, I HEREBY GIVE CONSENT FOR THE TREATMENT OF MY CHILD.

_____
(SIGNATURE)

CONSENT FORM FOR MEDICAL TREATMENT AND RELEASE OF INDIVIDUAL HEALTH INFORMATION

I give permission to release heath information necessary to my treatment and the processing of insurance claims to the following:

1. Billing Services
2. Individual Insurance Companies
3. Physicians Associated With My Care
    a. Consulting
    b. Referring
4. Hospital Lab and Procedural Departments
5. Agencies Associated With My Care
    a. Home Health
    b. Pharmacy
    c. Durable Medical Equipment
    d. Other
6. Significant Others/Family Members/Relatives
    Specifically: _____
    _____
    _____
    _____
7. If patient is a minor, permission is given for the following individuals to obtain medical treatment and health information on my child's behalf:
    Specifically: _____
    _____
    _____

_____

Patient's Name Date of Birth Signature
(I have received the Notice of Health Information Privacy Practices)

_____

If Patient is Minor - Parent/Guardian Signature Date

It is the patient's responsibility to notify this office of any changes or revision to the above consent.

Family History Sheet

Patient:_____
Date of Birth: _____

Problem	Relationship to Patient	Details	Problem	Relationship to Patient	Details
heart defect			tuberculosis		
heart attack before age 55			cancer		
high cholesterol			smoking		
high blood pressure			alcohol or drug abuse		
thyroid disease			birth defects		
diabetes-Type I			infertility		
diabetes-Type II			stomach/ bowel diseases		
anemia					
skin problems			kidney problems, including reflux		
eye disease			lead poisoning		
hearing loss			lung problems (asthma, etc)		
dislocated hips			muscle problems		
seizures with fever			allergies		
seizures without fever			bone problems		
depression, schizophrenia, etc.(specify)			arthritis		
learning problems/ADHD			other (specify)		

Sometimes spiritual beliefs or family traditions are important in a child's medical care. Is there anything you would like us to be aware of when we re treating your child?

_____

_____

Patient History Sheet

Patient Name: _____
Date of Birth: _____

Parent/Guardian(s) _____
_____

Brothers/Sisters (names, ages) _____

Past History:

Birth Weight_____ Vaginal or C-section_____ Vertex (head down) or breech_____

Birth complications_____

Newborn problems_____

Allergies to medications: _____

Other allergies: _____

Illnesses / problems

Type of Problem	Date(s)	Comments	Type of Problem	Date(s)	Comments
chicken pox			stomach problems		
bronchitis/wheezing/ asthma			thyroid problems		
allergy symptoms			diabetes		
bedwetting>age 6			chronic headaches		
seizures with fever			eye problems		
other seizures			hearing problems		
learning problems			broken bones		
slow developments			heart problems		
frequent ear infections			bladder/kidney infection		
chronic skin problem			bacterial pneumonia		

Hospitalizations: _____
_____
_____

Surgeries:
_____
_____
_____

Any other problems:
_____
_____
_____

Does your family use alternative medical treatments such as chiropractors, herbal medications, or homeopathy? (Describe)
_____