



JENNIFER MADON M.D.
 101G W. NORTHSIDE DRIVE
 VALDOSTA, GA. 31602

PEDIATRIC INFORMATION SHEET

DATE _____ ACCOUNT # _____

Patient Information

NAME _____ SOCIAL SEC. # _____
 (FIRST) (M) (LAST)

STREET ADDRESS _____ CITY _____

STATE _____ ZIP _____ COUNTY _____ SEX: M / F RACE _____ DOB _____

AGE _____ HOME PHONE _____ OTHER PHONE _____ CELL # _____

E-MAIL _____

Mother's Information

NAME _____ MAIDEN NAME _____ DOB _____

SS # _____ EMPLOYMENT _____ WK# _____

Father's Information

NAME _____ DOB _____

SS # _____ EMPLOYMENT _____ WK# _____

Medical Insurance Information: PROVIDE A COPY OF EACH INSURANCE CARD

Primary Policy Holder Name _____

PRIMARY INS. _____ SECONDARY INS. / MEDICAID _____

PERSON TO NOTIFY IN CASE OF EMERGENCY, OTHER THAN PATIENT

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ PH _____

INFORMATION ON FORM IS PROTECTED HEALTH INFORMATION (PHI) AND IS TO BE TREATED AS CONFIDENTIAL UNDER HIPPA RULES - PRIVACY & SECURITY OF THIS INFORMATION IS ESSENTIAL. ALL SERVICES ARE CHARGED DIRECTLY TO THE PATIENT, AND THE PATIENT OR THE PATIENT'S REPRESENTATIVE REMAINS PERSONALLY RESPONSIBLE FOR PAYMENT, AS A COURTESY, WE WILL FILE INSURANCE CLAIMS FOR OUR PATIENTS; HOWEVER, **THE PATIENT'S PORTION OF THE FEE AND/OR CO-PAYS IS - DUE AT THE TIME OF SERVICE.**
ACKNOWLEDGEMENT ; I CONSENT TO USE OF PHI FOR PURPOSES OF TREATMENT, PAYMENT AND OPERATIONS AND, AUTHORIZE THE ENTITY TO USE THE PHI AS NEEDED. I AUTHORIZE THAT PAYMENT OF BENEFITS, INCLUDING MEDICARE BENEFITS, BE MADE ON MY BEHALF DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY **RESPONSIBLE** FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. IN MEDICARE ASSIGNED CASE, THE PHYSICIAN AGREES TO ACCEPT THE CHARGES DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE AND THE PATIENT IS RESPONSIBLE FOR THE DEDUCTIBLE, COINSURANCE AND NONCOVERED SERVICE.

 PATIENT SIGNATURE REPRESENTATIVE SIGNATURE DATE



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This patient history form and the information you provide is very important to your healthcare and treatment. Please take the time to fully and accurately complete this patient history questionnaire.

**Thank you,
Dr. Jennifer Madon, M.D.**

THIS INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY BELIEF.

Patient/Parent/Guardian Signature

Date



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MEDICAL HISTORY FORM

GENERAL Have you had any of the following in the past six months, or suffer from these chronically? (Please place a check mark to those that apply).

ENDOCRINE

- Swelling under arms or neck
- Weakness and lethargy
- Always hungry
- Increased thirst
- Increased urination
- Tend to be too hot
- Tend to be too cold
- Fever and chills
- Night sweats
- Problems going to sleep
- Problems waking up after falling asleep
- Recent weight gain
- Recent weight loss
- Diabetes

PSYCHIATRIC

- Depression
- Anxiety
- Cry often
- Feel sad
- Loss of self-interest
- Loss of interest in eating
- Hear voices
- Nervous breakdown

EARS, NOSE & THROAT

- Wear glasses or contacts
- Eye discharge
- Blurry vision
- Recent changes in vision
- Decreased hearing
- Earache or drainage
- Ringing in ears
- Allergies
- Sinus trouble
- Nose bleeds
- Sore throat
- Sores on the tongue
- Goiter/thyroid problems
- Neck pain or lumps
- Any change in voice
- Dental problems
- Sores in the mouth

INFECTIONS

- Rheumatic fever
- Measles
- Mumps
- Chicken pox
- Hepatitis B
- Hepatitis C
- Polio
- AIDS (or positive test)
- Syphilis (or other sexually transmitted diseases)

PULMONARY

- Chronic snoring
- Persistent cough
- Coughing up blood
- Coughing up secretions each morning
- Stopped breathing while asleep
- COPD, emphysema or chronic bronchitis
- Asthma

HEMATOLOGY

- Anemia/low blood count
- Blood disease
- Sickle cell disease
- Radiation exposure
- Bleeding/bruising easily
- Skin cancers
- Other cancers (Please indicate on back of form)

MUSCULOSKELETAL

- Gout
- Pain in fingers or hands after exposure to cold
- Muscle or joint pain
- Leg cramps after walking
- Leg cramps at night
- Arthritis

NEUROLOGY

- Frequent headaches
- Migraines
- Seizures
- Stroke or paralysis
- Memory problems
- Meningitis
- Nerve damage to feet or hands
- Trembling spells

CARDIOVASCULAR

- Chest pain
- Heart palpitations
- Dizzy upon standing
- Swelling in feet/hands
- High cholesterol
- Fainting spells
- Shortness of breath with exercise
- Having to sit up intermittently at night
- Prior heart surgery

GASTROINTESTINAL

- Heartburn
- Belching
- Loss of appetite
- Nausea or vomiting
- Liver disease
- Jaundice or hepatitis
- Difficulty swallowing
- Stomach pain
- Recent change in bowel habits
- Diarrhea
- Constipation
- Bloody stools
- Rectal pain
- Hemorrhoids
- Rectal fissure
- Parasites or worms
- Pancreatitis

GENITOURINARY

- Frequent urination
- Burning on urination
- Difficulty starting urination
- Dribbling of urine with cough
- Kidney stones
- Kidney disease
- Sexual difficulty

MEN ONLY

- Weak urine stream
- Prostate problems
- Lump on testicle(s)
- Problem with sexual intercourse
- Burning or discharge

WOMEN ONLY

- Cesarean section
- Hysterectomy
- Toxemia during pregnancy
- Diabetes during pregnancy
- Lumps in breast
- Date/last pap smear
- Pregnancies
- No. of miscarriages
- Date of last period
- Menstrual problems
- Excessive menstrual bleeding

ALLERGIES (List)

SURGERIES (List)

Family History: Mother: _____

Father: _____

MEDICATION LIST: _____



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HIPAA AND OUR PATIENTS

* The **HIPAA** (Health Insurance Portability and Accountability Act) Privacy Rule became law in April 2001. This rule essentially controls the use and disclosure of what is known as Protected Health Information. Implementation of and compliance with this rule is not optional for our practice. We are required to give you the attached information.

* Please read and familiarize yourself with the attached material. It is your copy so feel free to take it with you.

* Sign this page and turn it in to the medical assistant taking care of you. It will be a permanent part of your medical record.

FROM: _____
PATIENT'S NAME

TO: JENNIFER MADON, M.D.

RE: HIPAA NOTICE OF PRIVACY PRACTICES

As a patient of the above physician, I acknowledge receipt of the HIPAA Notice of Privacy Practices.

PATIENT SIGNATURE

DATE

OR

PATIENT'S REPRESENTATIVE
(PARENT/GUARDIAN)

DATE



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For all patients:

Please make sure that all parties including your contact person for emergency situations are listed on the attached power of attorney form.

Without this authorization we cannot authorize any treatment for pediatric patients for a child brought by someone else other than parents and/or release any medical information including prescription pick up and medical records to anyone other than the parties on this form.

Thanks for your cooperation.

Jennifer Madon, M.D.



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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON I DESIGNATE (MY AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR MY DEPENDENT CHILD, INCLUDING POWER TO CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT.

DESIGNATION OF HEALTH CARE AGENT:

I, _____, _____, HEREBY APPOINT:
(PRINTED NAME) (SOCIAL SECURITY NUMBER)

AGENT NAME: _____

ADDRESS: _____

PHONE: _____

RELATIONSHIP: _____

AS MY ATTORNEY-IN-FACT (MY AGENT) TO ACT FOR ME AND IN MY NAME IN ANY WAY I COULD ACT IN PERSON TO MAKE ANY AND ALL DECISIONS CONCERNING THE PERSONAL CARE, MEDICAL TREATMENT, AND HEALTH CARE REQUIRED FOR MY DEPENDENT CHILD:

NAME OF CHILD: _____

SSN OF CHILD: _____

MY AGENT SHALL HAVE THE SAME ACCESS TO MY CHILD'S MEDICAL RECORDS THAT I HAVE, INCLUDING THE RIGHT TO DISCLOSE THE CONTENTS TO OTHERS.

DURATION: THIS POWER OF ATTORNEY SHALL REMAIN VALID UNTIL _____
(ENTER TERMINATION DATE OR "INDEFINITE")

HOLD HARMLESS PROVISION: ALL PERSONS OR ENTITIES WHO IN GOOD FAITH ENDEAVOR TO CARRY OUT THE TERMS AND PROVISIONS OF THIS DOCUMENT SHALL NOT BE LIABLE TO ME OR MY DEPENDENT CHILD OR RESPONSIBLE FOR ANY DAMAGES OR CLAIMS ARISING BECAUSE OF THEIR ACTION OR INACTION BASED ON THIS DOCUMENT.

STATEMENT OF INTENTIONS: IT IS MY INTENT THAT THIS DOCUMENT BE LEGALLY BINDING AND EFFECTIVE. IF THE LAW DOES NOT RECOGNIZE THIS DOCUMENT AS LEGALLY BINDING AND EFFECTIVE, IT IS MY INTENT THAT THIS DOCUMENT BE TAKEN AS A FORMAL STATEMENT OF MY DESIRE CONCERNING THE METHOD BY WHICH ANY HEALTH CARE DECISIONS SHOULD BE MADE ON MY BEHALF. I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I AM EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS DECLARATION.

SIGNATURE OF PERSON DESIGNATING AGENT: _____

WITNESS SIGNATURE: _____

NOTARY SIGNATURE: _____

SIGNED ON _____ DAY OF _____ YEAR _____