MADISON MEDICAL AFFILIATES, INC.

PATIENT INFORMATION

LEGAL NAME _____ DOB ____/_____/_____ SSN _____

ADDRESS _____CITY_____STATE_____ ZIP_____

Parent/Legal Guardian _____ MARITAL STATUS OF PATIENT _____

HOME PHONE _____ WORK PHONE _____CELL PHONE _____

EMAIL _____ For use with MySecureHealthData, our secure patient portal that allows you access to your medical information, our treatment plans and more. When you receive our email with the registration link, please enroll right away so you can stay informed *and* so we can more efficiently manage your care.

INSURANCE INFORMATION

PRIMARY INSURANCE NAME _____

Insured Name _____ Insured DOB _____

Member ID# _____ Member SSN _____

Relationship to Insured _____ Group# _____

SECONDARY INSURANCE or VISION PLAN _____

Insured Name _____ Insured DOB _____

Member ID#_____ Member SSN _____

Relationship to Insured_____ Group# _____

EMERGENCY CONTACT PERSON _____ PHONE _____

REFERRED BY _____ Family/ Doctor/ Friend/ Other _____

DUE TO NEW FEDERAL REGULATIONS, PLEASE COMPLETE THE FOLLOWING INFORMATION:

RACE - Caucasian ____ African American ____ Asian____ Other____ Decline to Answer_____

ETHNICITY - Hispanic/Latino____ Not Hispanic/Latino____ Unknown____ Decline to Answer_____

GENERAL- Male_____ Female_____ Height_____ Weight_____

By signing below, I give consent to the staff of Madison Medical Affiliates to view my prescription history as supplied by other health plans and with participating pharmacies. My signature also indicates I have provided Madison Medical Affiliates with my most current demographic and insurance information.

/ /

_____ _____

Print Patient name **Patient/ Guardian Signature** **Date**