MADISON
PRIMARY CARE

A Family Clinic

PATIENT REGISTRATION

Patient's Name: _____
Last Name, First Name, Middle Name, Name you go by

Address: _____
Street, City, State, Zip Code

Phone Numbers: _____YES_____NO_____
Home, Cell, Can we leave phone messages?

Sex: ___ DOB: _____ Age: ___ SSN: _____ Drivers License: _____ Marital Status: _____

Patient's Employer: _____ Occupation: _____ Work Phone: _____

Spouse's Name: _____
Last Name, First Name, Middle Name, Name goes by

Patient's Employer: _____ Occupation: _____ Work Phone: _____

EMERGENCY CONTACT

Contact Name: _____ Relationship: _____ Phone Number: _____

REFERRED BY & E-MAIL ADDRESS

Referred by: _____ How did you hear about us? _____

E-Mail Address: _____ Can we E-mail you appointment & other clinic information? Yes __ No __

INSURANCE INFORMATION

Primary Insurance: _____

Group #: _____ ID/Contract #: _____ Co-pay: _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____

Secondary Insurance: _____

Group #: _____ ID/Contract #: _____ Co-pay: _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____

Adeel A. Bodla, MD | Fakhra Ahmad-Bodla, CRNP
3776 Sullivan Street, Suite D, Madison, AL 35758
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Receipt of Privacy Practices; Consent to Use/Disclosure of Protected Health Information (PHI)

You will find a copy of our privacy practices posted in the clinic & on our website: MadisonPrimaryCare.com.
If you would like a copy for your own records, please check here. _____

I, _____, was offered a copy of Madison Primary Care's Privacy Practices Notification. Madison Primary Care may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Madison Primary Care to use or disclose my PHI in conjunction with their treatment, payment or healthcare option in accordance with the terms of this consent.

_____ _____
Signature of Patient/Guardian Date

Further I hereby authorize and give my consent to Madison Primary Care to leave messages on my answering machine/voicemail for the following (check all that apply)

Appointment reminders	____	Prescription Refills	____
Medical Information	____	Test Results	____
Insurance/Payment Issues	____	Mail	____

All other releases of your personal information will only be with your permission and authorized by a signature from you. THIS INCLUDES YOUR IMMEDIATE FAMILY UNLESS OTHERWISE DESIGNATED BELOW. In the event of an emergency, we will contact your designated emergency contact. You have the right to review or request copies of your records at any time. We request a 48 hours notice to allow us to accommodate you.

I further authorize and give consent to Madison Primary Care to communicate any of my PHI to the following person/persons:

Name	Relationship

_____ _____
Signature of Patient/Guardian Date

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Personal / Social Hx – Age 13 to Adult

Patient Name: _____

Drug and Food Allergies and Indicate Reaction: _____

Reason for Today's Visit: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you had any recent infection, illness or injury? _____

Last doctor: _____ Reason for leaving: _____

Other doctors/specialists involved in your care: _____

Race / Culture: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Asian
☐ Native Hawaiian or Pacific Islander ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced (# times: ____)

Do you have children? (list genders & ages)_____

Where do you live? (house , apartment, nursing home, etc.) _____

Who do you live with? (include all) _____

What activities do you have trouble doing by yourself?

☐ Eating	☐ Dressing	☐ Going to the bathroom	☐ Walking
☐ Bathing	☐ Getting out of bed	☐ Grooming	☐ Communicating

What activities are you NOT able to do?

		☐ Manage household	☐ Shopping
☐ Lifting	☐ Cooking	☐ Housecleaning	☐ Laundry
☐ Managing medications	☐ Managing money	☐ Manage home repair	☐ Driving
☐ Use public transportation		☐ Reading	☐ Writing

Current Job/Position: _____

Religious Preference: _____

Do you use tobacco? ☐ Cigarettes ☐ Chewing ☐ Snuff Packs per day _____ Number of years used _____

Were you previously a smoker? ☐ Yes ☐ No If so, year you quit _____ and # of years you smoked _____

Do you live in a house with a smoker? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Type & Amount: _____

Do you use drugs? ☐ Yes ☐ No If yes, what kind and how often? _____

Do you exercise regularly? ☐ Yes ☐ No If yes, what kind of exercise and how often? _____

Do you use a seatbelt? ☐ Yes ☐ No Do you use a helmet for biking/skateboarding? ☐ Yes ☐ No ☐ NA

Activities / Hobbies / Sports: _____

Education Completed: ☐ GED ☐ High School ☐ Tech School
☐ College ☐ Post Grad ☐ Other: _____

Are you enrolled in: ☐ Public School ☐ Private School ☐ Home school School Grade: _____

Name of School/ College attending: _____

Review of Systems

Please check the symptoms below that you have persistent problems with or are concerned about:

GENERAL

☐ Fever	☐ Chills	☐ Feeling Tired
☐ Weakness	☐ Weight Loss	☐ Weight Gain

SKIN/HAIR/NAILS/LYMPH

☐ Change in Skin Color	☐ Easy Bruising	☐ Pitted Nails
☐ Dry Skin	☐ Skin Lesions	☐ Mole Changes
☐ Rash	☐ Hair Symptoms	☐ Lesions
☐ Itching	☐ Fingernail Discoloration	☐ Swollen Lymph Nodes

JOINTS/MUSCLES

☐ Muscle Aches	☐ Localized Joint Swelling	☐ Muscle Weakness
☐ Joint Pain, Localized	☐ Localized Joint Stiffness	☐ Muscle Cramps
☐ Gout Attack	☐ Back Pain	☐ Knee Pain
☐ Varicose Veins	☐ Other Pain: _____	

ENDOCRINE SYSTEM

☐ Recent Weight Change	☐ Tremors	☐ Excessive Hunger
☐ Temperature Intolerance	☐ Excessive Thirst	☐ Excessive Urination

Review of Systems – continued

EYES

☐ Blurry Vision
☐ Double Vision
☐ Eye Pain
☐ Watery Drainage
☐ Mucous-Like Drainage

EARS / NOSE / MOUTH / THROAT

☐ Ear Pain
☐ Trouble Hearing
☐ Ringing in Ears
☐ Ear Drainage
☐ Sneezing
☐ Clear Nasal Drainage
☐ Nasal Drainage/Mucous
☐ Nasal Stuffiness
☐ Nosebleeds
☐ Snoring
☐ Sore Throat
☐ Difficulty Swallowing
☐ Change in Voice
☐ Jaw Pain
☐ Facial/Sinus Pressure
☐ Tooth Ache
☐ Bleeding Gums
☐ Mouth Sores

BREAST

☐ Breast Lump
☐ Breast Pain (females)
☐ Nipple Discharge (females)

RESPIRATORY SYSTEM

☐ Cough
☐ Coughing up Blood
☐ Night Sweats
☐ Exposed to TB
☐ Shortness of Breath
☐ Trouble Sleeping Flat
☐ Coughing Up Sputum

CARDIOVASCULAR SYSTEM

☐ Palpitations
☐ Chest Pain
☐ Difficulty Breathing
☐ Soft Tissue Swelling

GASTROINTESTINAL SYSTEM

☐ Appetite
☐ Difficulty Swallowing
☐ Nausea
☐ Belching
☐ Heartburn
☐ Flatulence (Gas)
☐ Abdominal Pain
☐ Diarrhea
☐ Constipation
☐ Vomiting
☐ Stool Changes
☐ Bloody Stool
☐ Black Stool

GENITOURINARY SYSTEM

☐ Decreased Urine Volume
☐ Pain during Urination
☐ Blood in Urine
☐ Changes in Urinary Habits
☐ Urinary Loss of Control
☐ Birth Control Method: _____
☐ History of Venereal Disease
☐ Sexual Complaints

GENITOURINARY SYSTEM – *Females Only:*

☐ Vaginal Discharge
☐ Vulvar Itching/Burning
☐ Age at first period: _____
☐ Abnormal Menses Frequency
☐ Abnormal Menses Duration
☐ Heavy Bleeding
☐ Severe Menstrual Pain
☐ Vaginal Dryness
☐ Date of last Menstruation: _____
☐ Age at Menopause: _____
☐ Postmenopausal Bleeding

Summary of Previous Pregnancies:
Pregnancies: _____
Full-Term Deliveries: _____
Premature Deliveries: _____
Vaginal Deliveries: _____
C-Section Deliveries: _____
Living Children: _____
Miscarriages: _____
Elective Abortions: _____
Ectopic (Tubal) Pregnancies: _____

GENITOURINARY SYSTEM – *Males Only:*

☐ Testicle Symptoms
☐ Blood in Semen
☐ Abnormal Urethral Discharge
☐ Penile Lesion
☐ Decreased Urine Flow
☐ Urinary Urgency
☐ Urinary Hesitancy
☐ Frequent Urination at Night

NEUROLOGICAL SYSTEM

☐ Sense of Smell Changes
☐ Taste Disturbances
☐ Difficulty Keeping Balance
☐ Difficulty in Speech
☐ Abnormality of Walk
☐ Increased Sensitivity to Touch / Pain
☐ Tingling
☐ Numbness
☐ Headache
☐ Fainting
☐ Dizziness
☐ Confusion
☐ Memory Loss
☐ Vertigo

PSYCHIATRIC HISTORY

☐ Interpersonal Relationship Problems
☐ Sleep Disturbances
☐ Depression
☐ Anxiety
☐ Memory Lapses / Loss
☐ Hallucinations
☐ Thoughts of Hurting Yourself
☐ Thoughts of Hurting Someone Else
☐ Agitation
☐ Restless
☐ Sadness

Past Medical Hx

Do you have a **Medical History** of *(check all that apply)*:

☐ Allergic Rhinitis	☐ Chronic Bronchitis	☐ Glaucoma/Eye Disease	☐ Osteoporosis
☐ Alzheimer's Disease	☐ Colitis	☐ Gout	☐ Peptic Ulcer
☐ Anemia	☐ Congestive Heart Failure	☐ Heart Attack	☐ Psychiatric Disorder
☐ Anxiety	☐ COPD	☐ Heartburn/GERD	☐ Renal / Kidney Disease
☐ Arthritis	☐ Crohn's Disease	☐ Heart Disease	☐ Seizure Disorder
☐ Asthma	☐ Dementia	☐ Hepatitis/Liver Disease	☐ Stroke Syndrome
☐ Birth Defects	☐ Depression	☐ High Cholesterol	☐ Substance Abuse
☐ Bleeding Disorder	☐ Diabetes Mellitus	☐ HIV Infection	☐ Thyroid Disorders
☐ Blood Clots	☐ Eczema	☐ Hypertension	☐ Tuberculosis
☐ Breast Lump	☐ Enlarged Prostate	☐ Lung Disease	☐ Other _____
☐ Cancer	☐ Genetic Disease	☐ Migraine Headaches	☐ Other _____

Surgery/Hospitalization

Please list any **Surgeries/Hospitalization** that you have had:

Surgery/Hospitalization/Injury	**Date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Do you have a **FAMILY HISTORY** of *(check all that apply & indicate your relationship to the person affected)*:

☐ Allergic Rhinitis _____	☐ Crohn's Disease _____	☐ Hypertension _____
☐ Alzheimer's Disease _____	☐ Dementia _____	☐ Lung Disease _____
☐ Anemia _____	☐ Depression _____	☐ Migraine Headaches _____
☐ Anxiety _____	☐ Diabetes Mellitus _____	☐ Osteoporosis _____
☐ Arthritis _____	☐ Eczema _____	☐ Peptic Ulcer _____
☐ Asthma _____	☐ Enlarged Prostate _____	☐ Psychiatric Disorder _____
☐ Birth Defects _____	☐ Genetic Disease _____	☐ Renal/Kidney Disease _____
☐ Bleeding Disorder _____	☐ Glaucoma/Eye Disease _____	☐ Seizure Disorder _____
☐ Blood Clots _____	☐ Gout _____	☐ Stroke Syndrome _____
☐ Breast Lump _____	☐ Heart Attack _____	☐ Substance Abuse _____
☐ Cancer/Type:_____ _____	☐ Heart Disease _____	☐ Thyroid Disorders _____
☐ Chronic Bronchitis _____	☐ Heartburn/GERD _____	☐ Tuberculosis _____
☐ Colitis _____	☐ Hepatitis/Liver Disease _____	Other: _____ _____
☐ Congestive Heart Failure _____	☐ High Cholesterol _____	Other: _____ _____
☐ COPD _____	☐ HIV Infection _____	

Medications

Please list any **medications** that you are currently taking: Dose/Frequency

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

IMM

Last Tetanus shot: _____ Last Flu Vaccine: _____

Last Pneumonia Vaccine: _____ Last Chicken Pox Vaccine: _____

Last HPV Vaccine: _____ Last Shingles Vaccine: _____

Health Maintenance

Males: *(Indicate the approximate date of your last screening test _____)*

Age 35 and older: Cholesterol level _____

Age 65-75 if ever smoked 100 or more cigarettes: Abdominal Aortic Aneurysm Screening _____

Age 50 or older: Colon Cancer Screening _____

Last blood work: _____

Last prostate cancer screening: _____

Last stress test: _____

Last eye exam: _____

Sexually Transmitted Diseases Screening (such as HIV, Gonorrhea, Syphillis, etc.) _____

Females: *(Indicate the approximate date of your last screening test _____)*

Age 40 and older: Mammogram _____

Age 21-65 or younger and sexually active for 3 years: Pap Test _____

Age 45 and older: Cholesterol level _____

Age 65 and older OR 60-64 and weigh less than 155 pounds: Bone Density _____

Age 50 or older: Colon Cancer Screening _____

Last blood work: _____

Last stress test: _____

Last eye exam: _____

Last dexa scan: _____

Age 25 and younger and sexually active: Chlamydia test _____

Other Sexually Transmitted Diseases Screening (such as HIV, Gonorrhea, Syphillis, etc.) _____

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Office & Financial Policies

Thank you for choosing Madison Primary for your health care needs. In an effort to make your transition to our practice as smooth as possible we have the following policies that we request you read & sign. Please feel free to seek clarification on any of our policies.

Madison Primary Care's Providers: Adeel A. Bodla, MD & Fakhra Ahmad-Bodla, CRNP

Our Mission: Our primary policy is to provide our patients with the highest quality of health care within the scope of our specialty – Family Medicine.

Office Hours: Monday – Friday 8-5pm with Lunch from 12-1pm. Extended or after-hours appointments can be made by appointment. Call 911 in the event of any life threatening emergency. An after-hours answering service is always able to contact the on call provider for urgent issues. We welcome you to use this service anytime you have serious concerns or questions. Please use our regular business hours for all non-urgent issues.

Messages: We strive to return patient calls on the same day. Non-urgent calls will be returned within 48 hours.

Medications: Please make every effort to have any routine medication refills called in during regular office hours so that we can have your medical records available to safely prescribe your medication.

We strive to have zero errors related to your prescriptions & medications. Therefore, please bring all prescription bottles to each appointment. To provide the best care possible, we prefer to write new and refill prescriptions during office visits. If possible, we will write you enough refills to last until your next appointment. Prescriptions may be picked up by the patient, parent/guardian, or persons listed on the Disclosure Release. We are not able to call in any controlled substances over the phone.

First Visit: New patient forms are available online & we ask that you complete these forms prior to your appointment time. Forms are also available in the office, and we ask that you arrive 20 minutes before your appointment to complete the forms & registration process. We require a pediatric or adult history packet (which also includes an acknowledgement of our privacy policies) & a signed copy of our office/financial policies. You may also have prior records sent to us by completing a release of medical records. Forms, past medical history & immunization records may be faxed to us in advance for the doctor to review at 256-774-5523.

Controlled Substances: Because we do not provide **chronic** pain management services with controlled substances or narcotics- any chronic pain needs or other medical conditions requiring long-term controlled substances treatment will be referred to providers who can better manage your healthcare needs.

Insurance: Insurance claims will be filed for you as a courtesy. Please be familiar with the terms and policies of your insurance plan. If you have a deductible, which has not been met, or your insurance deems your visit as a non-covered service you will be responsible for the balance. The terms of your insurance policy are between you and your insurance company. Any questions or problems with your insurance should be directed to your individual insurance company. We require all co-payments on the day of service. There will be a $25.00 charge on all returned checks.

3584-203 7/11

Appointments: Time is valuable for all of us & we want to give you and your health issues our utmost attention Therefore if you arrive more than 20 minutes late for your appointment, you may be asked to reschedule in order to be fair to the other patients who arrive on time. We ask that you kindly give at least 24 hours notice when cancelling an appointment. We will charge $25.00 for appointments canceled within 24 hours of your appointment. By failing to cancel or re-schedule your appointment three or more times we will respectfully ask you to find another health care provider.

At this time we do not offer "walk-in" appointments. However, we do have several slots during the day for same-day and urgent problems. Please call early in the day so we can accommodate your needs. We will make every effort to see you on time & also ask for your understanding in the event we are running behind schedule as unforeseen emergencies and complex patients may warrant additional doctor time in the clinic & hospital. Our staff is committed to keeping you informed of delays and giving you options to manage your valuable time.

Health Forms & Records: We understand that health forms are required by many agencies, and we will be happy to fill these out during your appointment free of charge if it does not delay the care of other patients. Lengthy forms may have to be completed and picked up later. Any form completion requested outside of an office visit will be subject to a $25.00 charge.

In order to insure accuracy & safety of your medical information, all of our medical records are in digital format. Copies of your medical records are available to you with a signed medical release. We do not charge for doctor-to-doctor medical record transfers. However, to cover costs we do charge the standard $0.50 per page for personal copies of records that are printed.

Identification: All patients will need to bring their current drivers license or photo ID and an updated insurance card to each appointment. We depend on accurate information to file your insurance claim. Incorrect information can result in the denial of your claim.

Inpatient Care: We believe in continuity of care & in most cases will treat our own patients in the hospital.

Patient Dismissal: We sincerely hope that we never have to part ways with a patient. However, extreme circumstances may make this necessary. If this occurs, you will be notified by certified mail. You will have 30 days to find another doctor during which we will continue to offer urgent care services only.

Having read the above, I agree to abide by the policies set by Madison Primary Care. I realize that all charges incurred by me and my dependents are my financial responsibility and all court fees, attorney fees, or other fees necessary to collect any past due balances are my responsibility. Failure to follow these policies could result in my dismissal as a patient. I confirm that the information that I have provided is true and correct. I have signed these policies of my own free will.

Patient/Guardian Signature: _____ **Relationship:** _____

Printed name: _____ **Date:** _____