MADISON
PRIMARY CARE

A Family Clinic

## PEDIATRIC 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 Lic: _____ Marital Status: _____

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

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

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

Mother'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
Office 256-774-5524 | Fax 256-774-5523
www.MadisonPrimaryCare.com

MADISON
PRIMARY CARE

A Family Clinic

## 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

**Adeel A. Bodla, MD | Fakhra Ahmad-Bodla, CRNP**
3776 Sullivan Street, Suite D, Madison, AL 35758
Office 256-774-5524 | Fax 256-774-5523
www.MadisonPrimaryCare.com

MADISON
PRIMARY CARE

## Personal Hx – Birth to Age 12

**Patient Name:** _____

Drug and Food Allergies and Indicate Reaction: _____

Reason for Today's Visit: _____

Last doctor: _____ Reason for leaving: _____

Other doctors/specialists involved in your care: _____

Child's dentist and last visit: _____

Brush teeth at least twice a day? _____

Any history of blood transfusions? ☐ Yes ☐ No

Any recent infection, illness or injury? _____

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

Where does child live? (house , apartment, etc.) _____

Who does child live with? (include all) _____

Does child have WIC support? ☐ Yes ☐ No Is child exposed to secondhand smoke at home? ☐ Yes ☐ No

Has your child been exposed to lead (old home, peeling paint etc.)? _____

What is your home water source? ☐ City Water ☐ Well Water ☐ Other: _____

Does child use a car seat / seatbelt? ☐ Yes ☐ No

Does child use a helmet for biking, skateboarding, etc? ☐ Yes ☐ No

Religious Preference: _____

Is child enrolled in: ☐ Daycare ☐ Preschool ☐ Stays at Home
☐ Public School ☐ Private School ☐ Home School ☐ School Grade: _____

Name of Daycare / Preschool / School: _____

How are your child's grades in school? _____

Is your child having any school problems? _____

## Birth Hx

Is your child a member of your family by: ☐ Birth ☐ Adoption ☐ Step-Child ☐ Other: _____

Birth Weight: _____ Born prematurely? ☐ Yes ☐ No

Vaginal Delivery? ☐ Yes ☐ No C-Section Delivery? ☐ Yes ☐ No

Were there any complications during the pregnancy, delivery or newborn hospitalization? ☐ Yes ☐ No

If yes, please describe: _____

## Develop-ment

At what age did your child:

Sit Alone: _____ Walk Alone: _____

Start Talking: _____ Potty Trained: _____

Start Reading: _____ 1st Menses for girls: _____

## Nutrition

**Infants:** ☐ Breastfeeding ☐ Formula

Indicate how many ounces and how often: _____

Indicate if your infant is taking any cereal/solids: _____

Any juice/how many ounces per day: _____

**Children:** ☐ Whole milk ☐ 2% milk ☐ Skim milk

Indicate how many ounces and how often: _____

Any juice/soda, indicate how many ounces per day: _____

Does your child get adequate servings of? (Check off all that apply):

☐ Dairy ☐ Meat ☐ Fruit ☐ Vegetables ☐ Carbohydrates ☐ Fats

Are you concerned about your child's weight? _____

## Activities/ Hobbies

How many hours a day does your child:
Watch TV _____ Use the Computer ____ Play Video Games _____ Read _____ Exercise/Play Outside _____
List all sports your child is involved with: _____
Are all safety measures and protective equipment used? ☐ Yes ☐ No _____
List any other activities your child does for fun: _____

## Risky Behaviors

Has your child been involved with any of the following (Check all that apply):
☐ Drugs ☐ Alcohol ☐ Smoking ☐ Sexual Activity ☐ History of Abuse ☐ Guns ☐ Gangs

## Past Medical Hx

Does child have a **Medical History** of *(check all that apply)*:

| | | |
|---|---|---|
| ☐ Anemia | ☐ Heart Disease | ☐ Hepatitis |
| ☐ Arthritis | ☐ Hypertension | ☐ Psychiatric Disorder |
| ☐ Asthma | ☐ Renal / Kidney Disease | ☐ Peptic Ulcer |
| ☐ Allergic Rhinitis | ☐ Migraine Headaches | ☐ Eczema |
| ☐ Cancer | ☐ Thyroid Disorders | ☐ Other _____ |
| ☐ Diabetes Mellitus | ☐ Tuberculosis | ☐ Other _____ |
| ☐ Seizure Disorder | ☐ HIV Infection | |

## Surgery/Hospitalization

Please list any **Surgeries/Hospitalization** that the child has had:

| Surgery/Hospitalization/Injury | Date |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## Family History

Does child have a **FAMILY HISTORY** of *(check all that apply and indicate your relationship to the person affected)*:

| | | |
|---|---|---|
| ☐ Anemia _____ | ☐ Glaucoma _____ | ☐ HIV Infection_____ |
| ☐ Arthritis _____ | ☐ Heart Attack _____ | ☐ Hepatitis _____ |
| ☐ Asthma _____ | ☐ Heart Disease _____ | ☐ Psychiatric Disorder _____ |
| ☐ Allergic Rhinitis _____ | ☐ Hypertension _____ | ☐ Peptic Ulcer _____ |
| ☐ Cancer _____ | ☐ Renal / Kidney Disease _____ | ☐ Eczema _____ |
| ☐ High Cholesterol _____ | ☐ Stroke Syndrome _____ | ☐ Substance Abuse_____ |
| ☐ Diabetes Mellitus _____ | ☐ Migraine Headaches _____ | ☐ Birth Defects _____ |
| ☐ Seizure Disorder _____ | ☐ Thyroid Disorders _____ | ☐ Genetic Disease _____ |
| | ☐ Tuberculosis _____ | |

## Medications

Please list any **medications** that your child is currently taking:

| Medications/Vitamins | Dose/Frequency |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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 Stiffness ☐ Other Pain:
☐ Joint Pain, Localized ☐ Muscle Weakness _____
☐ Localized Joint Swelling ☐ Muscle Cramps

**ENDOCRINE SYSTEM**

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

**EYES**

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

**EARS / NOSE / MOUTH / THROAT**

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

**BREAST**

☐ Breast Lump ☐ Breast Pain (females)

**RESPIRATORY SYSTEM**

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

**CARDIOVASCULAR SYSTEM**

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

**GASTROINTESTINAL SYSTEM**

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

**GENITOURINARY SYSTEM**

☐ Decreased Urine Volume ☐ Urinary Loss of Control
☐ Pain during Urination
☐ Blood in Urine
☐ Changes in Urinary Habits

**GENITOURINARY SYSTEM – *Females Only:***

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

Review of Systems – continued

**GENITOURINARY SYSTEM – *Males Only:***

☐ Testicle Symptoms
☐ Blood in Semen
☐ Abnormal Urethral Discharge
☐ Penile Lesion

**NEUROLOGICAL SYSTEM**

☐ Sense of Smell Changes
☐ Taste Disturbances
☐ Difficulty Keeping Balance
☐ Difficulty in Speech
☐ Abnormality of Walk
☐ Tingling
☐ Numbness
☐ Headaches
☐ 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

Do you have a copy of your child's immunization record? ☐ Yes ☐ No

**Please indicate date of vaccines if known and bring child's vaccine record to the 1st appointment and anytime a vaccine is given thereafter outside of our clinic.**

| | | | | | |
|---|---|---|---|---|---|
| **HEBATITIS B (3)** | | | | | |
| **DTaP (5)** | | | | | |
| **HIB (4)** | | | | | |
| **PNEVNAR (4)** | | | | | |
| **ROTAVIRUS (3)** | | | | | |
| **POLIO (4)** | | | | | |
| **MMR (2)** | | | | | |
| **VARICELLA (2)** | | | | **Had Disease Date:** | |
| **HEB A (2)** | | | | | |
| **MENINGOCOCCAL (1)** | | | | | |
| **GARDASIL (3)** | | | | | |
| **LAST INFLUENZA** | | | | | |
| **TDAP** | | | | | |

MADISON
PRIMARY CARE

A Family Clinic

## 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:** _____