

**THE FAMILY PRACTICE OF MADISON  
(256) 464-9991**

**JUDY P. RAWLS, M.D.**

SUSAN L. FURTWENGLER, C.R.N.P.

JENNIFER GRIFFIS, NP-C

ROBERTA JO BACKEL, C.R.N.P.

**PATIENT REGISTRATION SHEET**

**PATIENT INFO**

FIRST \_\_\_\_\_ MI \_\_\_\_\_ LAST \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PH \_\_\_\_\_ WORK PH \_\_\_\_\_  
CELL PH \_\_\_\_\_ DOB \_\_\_\_\_  
GENDER M  F  SSN \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_  
PRIMARY LANGUAGE \_\_\_\_\_  
HISPANIC Y  N  RACE \_\_\_\_\_  
MARITAL STATUS M  S  D  W   
EMPLOYER'S NAME \_\_\_\_\_  
EMPLOYER'S ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
NAME OF EMERGENCY CONTACT NOT SAME ADDRESS  
NAME \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

**PRIMARY INSURANCE INFO – POLICY HOLDER**

FIRST \_\_\_\_\_ MI \_\_\_\_\_ LAST \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PH \_\_\_\_\_ WORK PH \_\_\_\_\_  
EMPLOYER'S NAME \_\_\_\_\_  
EMPLOYER'S ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
SSN \_\_\_\_\_ DOB \_\_\_\_\_  
GENDER M  F   
MARITAL STATUS M  S  D  W   
NAME OF PERSON RESPONSIBLE FOR PAYMENT  
FIRST \_\_\_\_\_ MI \_\_\_\_\_ LAST \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE CO \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
POLICY/CONTRACT # \_\_\_\_\_  
GROUP NUMBER \_\_\_\_\_  
NAME OF POLICY HOLDER \_\_\_\_\_

SECONDARY INSURANCE CO \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
POLICY/CONTRACT:# \_\_\_\_\_  
GROUP NUMBER \_\_\_\_\_  
NAME OF POLICY HOLDER \_\_\_\_\_

ASSIGNMENTS OF BENEFITS AND/OR GUARANTEE OF ACCOUNT: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE FAMILY PRACTICE OF MADISON FOR THE BENEFIT'S PAYABLE UNDER THE TERMS OF MY POLICY FOR MY ILLNESS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE INCLUDING ALL COST OF COLLECTION AND REASONABLE ATTORNEY'S FEES.

DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SIGNATURE \_\_\_\_\_

**PAYMENT IS DUE AT TIME OF SERVICE**

## **YOUR RIGHT TO PRIVACY**

*We at the Family Practice of Madison respect your right to privacy. Therefore, our physicians and staff will only access and use your PHI (Protected Health Information) for the following TPO (Treatment, Payment, and Healthcare Operations):*

- 1. To provide your care here in our office*
- 2. To collect payment from your insurance company*
- 3. To assist your pharmacy in filling your prescriptions*
- 4. To coordinate your care with your other physicians, past or present. It is important that your care be coordinated with all of your doctors*
- 5. When a minor reaches the age of fourteen, we can no longer discuss the child's private medical information with a parent without the child present or written consent from the child. The exception is as follows: if a minor seeks medical treatment and wishes to use the parent's insurance policy, it is the policy holder's right to know what their insurance company has been billed for. If the minor does not wish for the policy holder to be given that information, the must pay cash at the time of service.*

*\*\*\*All other releases of your PHI (Protected Health Information) will only be with your permissions, authorized with 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 that you give us 48 hours notice in order to accommodate your request.*

*I give permission for information to be left on my answering machine/voicemail at the following number:*

\_\_\_\_\_.

*I authorize the staff of The Family Practice of Madison to discuss my care with the following people:*

Name \_\_\_\_\_ Phone number \_\_\_\_\_

Name \_\_\_\_\_ Phone number \_\_\_\_\_.

*I understand and consent to the use of my PHI (Protected Health Information) for the above purposes.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **THE FAMILY PRACTICE OF MADISON, P.C. INFORMATION AND POLICIES**

*In order to make your transition to our practice as simple as possible, below are some policies that you will need to read and sign. We look forward to serving you as our patient.*

- 1. Dr. Judy Rawls graduated from David Lipscomb University, Nashville, TN with a B.S. She obtained her M.D. from the University of Alabama School of Medicine in Birmingham, AL and completed a Family Medicine residency at the Carraway Medical Center in Birmingham, AL. She is board certified by The American Board of Family Medicine.*
- 2. Susan Furtwengler, C.R.N.P. graduated from Vanderbilt University with a B.S. and then from Vanderbilt University School of Nursing with a Masters of Science in nursing. She is a certified family nurse practitioner from the American Nurses Credentialing Center.*
- 3. Jennifer Griffis, NP-C graduated from the University of North Alabama with a B.S. She received her Masters of Science in Nursing from the University of Alabama at Birmingham. She is certified by the American Academy of Nurse Practitioners as a Family Nurse Practitioner.*
- 4. Roberta Jo Backel, C.R.N.P. graduated from the University of West Virginia with a B.S. and then from the University of West Virginia with a Masters of Science in nursing. She is a certified family nurse practitioner from the American Nurses Credentialing Center.*
- 5. Office hours are from 8:00 am to 4:00 pm Monday through Thursday & 8:00 am to 11:30 am on Fridays. During the week we will be available to you 24 hours a day. After hours calls are for emergencies only. In the event of an emergency, call our office number and our answering service will contact the physician on call.*
- 6. PRESCRIPTION REQUESTS REQUIRE 24 HOUR NOTICE. Antibiotics will not be called in under any circumstances without first seeing the doctor. Any routine medication refills will be called in during regular office hours only so that we can have your medical record available. Please bring all of your medications to your visits & request refills at that time.*
- 7. We prefer good quality preventive medicine to emergency only care. This is better medical care for you and your family. Please make an effort to establish with your caregiver a standard routine for medical care appropriate for your age and medical history. We are familiar with up-to-date standards for good health care for you. We also prefer to see you in the office instead of providing care via telephone.*
- 8. YOUR INSURANCE 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 (even with Blue Cross), you will be responsible for the balance. THE TERMS OF YOUR INSURANCE POLICY ARE BETWEEN YOU AND YOUR INSURANCE COMPANY. All copayments are due at the time of service. Collections fees will be charged if your account is turned over to our collection agency. In the case of divorced parents, the primary care giver will be responsible for any copayments or balances covered by insurance unless legal documentation is provided showing otherwise.*
- 9. There will be a \$20.00 charge on all returned checks. IF YOU MISS AN APPOINTMENT WITHOUT NOTIFYING THE OFFICE STAFF AT LEAST ONE HOUR PRIOR TO YOUR APPOINTMENT, A \$25.00 FEE WILL BE CHARGED TO YOUR ACCOUNT. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule in order to be fair to the other patients who arrive on time. In the same regard, we make our best effort to see our patients at the time of their appointment, but in the event of an unforeseen medical situation, please understand that if we are running behind, you will receive your physician's best care as soon as possible. We appreciate your patience.*
- 10. ALL PATIENTS WILL NEED TO BRING (A) CURRENT DRIVER'S LICENSE OR PHOTO ID AND (B) UPDATED INSURANCE CARD. If you do not bring your updated insurance card, you will be expected to pay in full*

*HAVING READ THE ABOVE, I AGREE TO ABIDE BY THE POLICIES SET BY THE FAMILY PRACTICE OF MADISON AND THE STAFF. I REALIZE THAT ALL CHARGES INCURRED BY ME AND MY DEPENDENTS ARE MY FINANCIAL RESPONSIBILITY AND ALL COURT FEES, ATTORNEY'S FEES, OR OTHER FEES NECESSARY TO COLLECT ANY PAST DUE BALANCES ARE MY RESPONSIBILITY. FAILURE TO FOLLOW THESE POLICIES COULD RESULT IN MY IMMEDIATE DISMISSAL AS A PATIENT. I HAVE SIGNED THESE POLICIES OF MY OWN FREE WILL AND IN RIGHT MIND.*

*Patient Signature* \_\_\_\_\_

*Date* \_\_\_\_\_

**Health History Intake Form**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Previous Primary Care Physician (if any): \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Other Physicians involved in your care: \_\_\_\_\_

Reason for visit today:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies** (Medication/Food, indicate reaction):  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication List:** (Please list name/dose/frequency if known)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Family History:** (please indicate deceased or alive, medical issues and age)

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

Grandparents: \_\_\_\_\_

ORIGINAL

**Habits:**

Alcohol:  None  Yes: How many drinks/day \_\_\_\_\_ frequency/week \_\_\_\_\_ What kind \_\_\_\_\_  
Tobacco:  None  Yes: Chew or smoke? \_\_\_\_\_ How many/day \_\_\_\_\_ since \_\_\_\_\_  
Caffeine:  None  Yes: What kind \_\_\_\_\_ How many/day \_\_\_\_\_  
Other Recreational Drugs:  None  Yes: What kind \_\_\_\_\_ How many/day \_\_\_\_\_  
Do you drive?  Yes  No Do you always wear a seatbelt?  Yes  No  
Do you exercise?  Yes  No If yes, how much? \_\_\_\_\_

**Social History:**

Work:  Employed  Unemployed  Retired  Disabled  
Current Occupation \_\_\_\_\_ Former Occupation \_\_\_\_\_  
Marital Status:  Married  Single  Divorced  Domestic Partner  
Sexual preference:  Men  Women  Both  
Children (age): \_\_\_\_\_  
Hobbies: \_\_\_\_\_  
Sports: \_\_\_\_\_  
Pets: \_\_\_\_\_  
Other: \_\_\_\_\_

**Past Surgical History (indicate date if known)**

- |  |   |
|--|---|
| <input type="checkbox"/> None                          | <input type="checkbox"/> Bariatric surgery _____          |
| <input type="checkbox"/> Cataracts _____               | <input type="checkbox"/> Hysterectomy _____               |
| <input type="checkbox"/> LASIK _____                   | <input type="checkbox"/> Endoscopy _____                  |
| <input type="checkbox"/> Tonsillectomy _____           | <input type="checkbox"/> Colonoscopy _____                |
| <input type="checkbox"/> Thyroidectomy _____           | <input type="checkbox"/> Hernia _____                     |
| <input type="checkbox"/> Adenoidectomy _____           | <input type="checkbox"/> Spinal Surgery _____             |
| <input type="checkbox"/> Coronary Bypass _____         | <input type="checkbox"/> Tubal Ligation _____             |
| <input type="checkbox"/> Cardiac Stents _____          | <input type="checkbox"/> Bladder surgery _____            |
| <input type="checkbox"/> Pacemaker _____               | <input type="checkbox"/> Prostate surgery/resection _____ |
| <input type="checkbox"/> Heart Valve _____             | <input type="checkbox"/> C-Section _____                  |
| <input type="checkbox"/> Gall Bladder _____            | <input type="checkbox"/> Orthopedic/joints _____          |
| <input type="checkbox"/> Appendectomy _____            | _____   |
| <input type="checkbox"/> Bowel/Stomach Resection _____ | <input type="checkbox"/> Other _____                      |
| <input type="checkbox"/> Hemorrhoidectomy _____        | _____   |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ORIGINAL

**Past Medical History:**

Head Aches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes (Type 1 or Type 2)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Thyroid Disease (Low or High)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Pulm Emboli (lung clots)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> DVT (leg clots)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Burn, Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stomach Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Coronary Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> MI/heart attacks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
<input type="checkbox"/> Valve Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Gastrointestinal Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hepatitis (A, B, C)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
HIV / AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chronic Wounds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer (type)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Urinary Tract Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
COPD (Emphysema, Bronchitis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bipolar Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Fibromyalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chronic Fatigue Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Prostate Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Breast Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Erectile Dysfunction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other _____			_____

ORIGINAL