

PATIENT REGISTRATION FORM
 (PLEASE PRINT)
BIRMINGHAM-SHELBY UROLOGY, P.C.

- PATRICK L. MILLS, SR., M.D., F.A.C.S.
 PATRICK L. MILLS, JR., M.D.
 JOHN T. WILBANKS, M.D.
 JASON K. BURRUS, M.D.

DATE	OFFICE USE ONLY

PATIENT INFORMATION

PATIENT'S LAST NAME		SUFFIX (JR, ETC.)	FIRST NAME		M.I.	NICKNAME			
PATIENT'S STREET ADDRESS				ZIP CODE	CITY		STATE		
SOC. SEC. NO.	HOME PHONE NO.	WORK PHONE NO.	CELL PHONE NO.	SEX		MARITAL STATUS		DATE OF BIRTH	
				M	F	S	M	W	D

RESPONSIBLE PARTY INFORMATION

RELATIONSHIP TO PATIENT	NAME OF RESPONSIBLE PARTY			SOC. SEC. NO.	DRIVER'S LICENSE NO.		
STREET ADDRESS				ZIP CODE	CITY		STATE
HOME PHONE NO.	WORK PHONE NO.	CELL PHONE NO.	NAME OF EMPLOYER (WORK)				
EMPLOYER'S STREET ADDRESS				ZIP CODE	CITY		STATE

REFERRED BY

(PRIMARY CARE PHYSICIAN IF REQUIRED BY INS. CO.)	ADDRESS (STREET, CITY, ZIP CODE)	PHONE NO.
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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY				SECONDARY INSURANCE COMPANY			
NAME OF INS. CO.				NAME OF INS. CO.			
GROUP NO.	POLICY NO.	EFFECTIVE DATE	GROUP NO.	POLICY NO.	EFFECTIVE DATE		
RELATIONSHIP TO PATIENT	NAME OF INSURED (AS IT APPEARS ON YOUR CARD)			RELATIONSHIP TO PATIENT	NAME OF INSURED (AS IT APPEARS ON YOUR CARD)		
DATE OF BIRTH	INSURED'S EMPLOYER	CO PAY	DATE OF BIRTH	INSURED'S EMPLOYER	CO PAY		

INJURY INFORMATION

JOB RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF INJURY	DATE LAST WORKED	EMPLOYER AT TIME OF INJURY	
WORKMEN'S COMPENSATION CARRIER		WHERE WERE YOU INJURED?		
HOW DID YOUR INJURY OCCUR?				EMPLOYER REP. WHO AUTHORIZED TREATMENT

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

PERSON TO CONTACT (OTHER THAN SPOUSE)		RELATIONSHIP	PHONE NO.
STREET ADDRESS		CITY	STATE
			ZIP

AUTHORIZATION AND RELEASE

CONSENT FOR TREATMENT - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize Birmingham-Shelby Urology, P.C. physicians to furnish any medical information requested by referring physicians, either to or from Birmingham-Shelby Urology, P.C. physicians; insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on-the-job injury.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to Birmingham-Shelby Urology, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Birmingham-Shelby Urology, P.C. charges for these services. I understand that I am financially responsible to Birmingham-Shelby Urology, P.C. for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by Birmingham-Shelby Urology, P.C. I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

SIGNATURE: _____ DATE: _____

Birmingham-Shelby Urology

1010 First Street North, Suite 200 ~ Alabaster, AL 35007
Phone (205) 663-1780 ~ (205) 664-3775

It may be necessary to contact you by phone concerning lab results, diagnostics tests and/or other medical reason. Legally, if we cannot reach you, we need your permission to leave information of any kind with someone else. Please read and complete the following:

Permission given to Dr. Mills, Sr., Dr. Mills, Jr. and Dr. Wilbanks office to leave our office name and number at my home _____ and/or office _____.

Permission given ___/not given ___ (Please Check One) to give my medical information to the following:

___ Spouse: Name _____ # _____

___ Parent: Name _____ # _____

___ Answering Machine: Home # _____

___ Answering Machine: Work # _____

___ Other: Name/# _____

Patient Signature _____ Date _____

BIRMINGHAM SHELBY UROLOGY, P.C.

EFFECTIVE DATE

06/01/2010

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact [insert the name, title, and phone number of the contact person or office responsible for handling complaints]. All complaints must be submitted in writing. You will not be penalized for filing a complaint. OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

[Practice Administrators: If you choose to have patients or their personal representatives sign this Notice, please use the lines below. Otherwise, the lines below should be removed.]

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient or Patient's Personal Representative

Date

BIRMINGHAM SHELBY UROLOGY, P.C.

PATRICK L. MILLS, SR. MD-PATRICK L. MILLS, JR. MD- JOHN T. WILBANKS MD-JASON K. BURRUS MD

DATE: _____

PATIENT NAME: _____ HT: _____ WT: _____ BP: _____ PULSE: _____

CHIEF COMPLAINT: _____

ALLERGIES: _____

PATIENT MEDICAL HISTORY:

DIABETES NO YES
 HYPERTENSION NO YES
 CANCER NO YES
 STROKE NO YES
 HEART TROUBLE NO YES
 ARTHRITIS NO YES
 GOUT NO YES
 OTHER: _____

PREVIOUS SURGERY:

MEDICATIONS FOR PATIENT

RACE:

___ WHITE
 ___ BLACK OR AFRICAN AMERICAN
 ___ HISPANIC OR LATINO
 ___ OTHER _____

FAMILY HISTORY:

MOTHER: _____

 FATHER: _____

 SIBLINGS: _____

PHARMACY NAME:

PHARMACY CITY:

PRIMARY CARE DOCTOR:

REFERRING DOCTOR NAME:

MARITAL STATUS: ___ SINGLE ___ MARRIED ___ SEPARATED ___ DIVORCED ___ WIDOWED

USE OF ALCOHOL: ___ NEVER ___ RARELY ___ MODERATE ___ DAILY

USE OF TOBACCO: ___ NEVER ___ PREVIOUSLY, BUT QUIT ___ CURRENT PACKS/DAY ___

USE OF ILLEGAL DRUGS: ___ NEVER ___ TYPE/FREQUENCY _____

PLEASE CIRCLE ANY OF THE FOLLOWING PROBLEMS YOU HAVE OR HAD IN RECENT PAST

Constitutional:	Fever	Weight Loss	Chills
Eyes:	Blurry Vision	Double Vision	Cataracts
Ears, Nose, Mouth Throat:	Hearing Loss	Nasal Stuffiness	Sore Throat
Cardiovascular:	Chest Pains	Swollen Ankles	Irregular Heartbeat
Respiratory:	Shortness of Breath	Wheezing	Chronic Cough
Genitourinary:	Incontinence	Painful Urination	Blood in Urine
Musculoskeletal:	Chronic Back Pain	Chronic Neck Pain	Sore Muscles
Integumentary/Skin:	Rash	Persistent Itching	Skin Cancer History
Neurological:	Numbness	Tingling	Dizziness
Hematologic/Lymphatic:	Swollen Glands	Abnormal Bleeding	Transfusion History