

DATE

OFFICE USE ONLY

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.

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	
HOME PHONE NO.	WORK PHONE NO.	CELL PHONE NO.	NAME OF EMPLOYER (WORK)		
EMPLOYER'S STREET ADDRESS			ZIP CODE	CITY	

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: _____