

(PLEASE PRINT)
PATIENT REGISTRATION FORM



DATE		<input type="checkbox"/> DEWEY H. JONES, III, M.D. <input type="checkbox"/> DEWEY H. JONES, IV, M.D. <input type="checkbox"/> GAYLON R. ROGERS, M.D.	
REFERRED BY (PRIMARY CARE PHYSICIAN IF REQUIRED BY INS. CO.)		ADDRESS (STREET, CITY, ZIP CODE)	
PATIENT INFORMATION			
PATIENT'S LAST NAME		FIRST NAME	M.I.
SOC. SEC. NO.	ADDRESS:		CITY
DATE OF BIRTH	SEX	MARITAL STATUS	RACE:
	M	F	S M W D
		HOME PHONE NO.	CELL PH. NO.
RESPONSIBLE PARTY INFORMATION			
LAST NAME		FIRST NAME	M.I.
HOME PHONE NO.	WORK PH. NO.	EXT.	CELL PH. NO.
ADDRESS:		CITY:	STATE
NAME OF EMPLOYER (WORK)		ADDRESS	STATE
INSURANCE INFORMATION			
PRIMARY INSURANCE COMPANY		SECONDARY INSURANCE COMPANY	
NAME OF INS. CO.		NAME OF INS. CO.	
POLICY OR ID NO.	GROUP OR PLAN NO.	POLICY OR ID NO.	GROUP OR PLAN NO.
PLAN CODE (BCBS ONLY)	EFFECTIVE DATE	CO-PAY	CO-PAY
POLICY HOLDER: LAST NAME		FIRST NAME	M.I.
DATE OF BIRTH	SEX	SOCIAL SECURITY NO.	RELATIONSHIP TO PATIENT
	M	F	
EMPLOYER NAME		WORK PHONE NO.	EMPLOYER NAME
INJURY INFORMATION			
JOB RELATED	DATE OF INJURY	DATE LAST WORKED	EMPLOYER AT TIME OF INJURY
<input type="checkbox"/> YES <input type="checkbox"/> NO			
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			

I hereby authorize BROOKWOOD ORTHOPEDICS, PHYSICIAN to release for insurance purposes any information acquired in the course of my examination and authorize payment directly to them of the Surgical and/or Medical Benefits, if any, otherwise payable to me for their services but not to exceed the reasonable and customary charge for their services. The undersigned agrees to pay all costs of collections including reasonable attorney's fees, and agrees to pay the legal rate of interest of the account until paid in full, and hereby waives all rights of exemption under the constitution and laws of the State of Alabama.

PATIENT'S SIGNATURE _____

PLEASE COMPLETE THE CONSENT FORM ON THE REVERSE SIDE.