



**Brookwood Medical Center**

513 Brookwood BLVD  
Brookwood Medical Plaza  
Suite 500  
Birmingham, Alabama 35209  
Phone: (205) 877-2767

**Childersburg Medical Surgical Center**

34011 Highway 280 East  
Childersburg, Alabama 35044  
Phone: (256) 378-3313

**Simon Mirelman, M.D., F.A.C.S.**

(Please Print Full Name)

PATIENT'S NAME \_\_\_\_\_ Patient's Age \_\_\_\_\_  
(Last) (First) (Middle or Maiden)

Patient's Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Social Security # \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_  
Patient's Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Referred By \_\_\_\_\_

Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_ Spouse's Name (if married) \_\_\_\_\_

Employer \_\_\_\_\_  
Work Phone # \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Occupation \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

**PHYSICIAN INFORMATION**

Referring Physician \_\_\_\_\_ Location \_\_\_\_\_  
Primary Physician \_\_\_\_\_ Location \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY (Not Living With Parents)**

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

**PERSON RESPONSIBLE FOR THIS BILL**

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Address \_\_\_\_\_

Phone # of Person Responsible \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Address of Employer \_\_\_\_\_  
(Street) (City) (State) (Zip)

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_

Contract #: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Insured DOB: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other

Secondary Insurance: \_\_\_\_\_

Contract #: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Insured DOB: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other

NOTE: AS A PATIENT OF SIMON MIRELMAN UROLOGY, I UNDERSTAND THAT I MAY BE REQUIRED TO HAVE ANY OR ALL OF THE FOLLOWING TESTS PRIOR TO HOSPITALIZATION OF SURGERY: (CBC) COMPLETE BLOOD COUNT, (U/A) URINALYSIS, AND (HTLV-3) AIDS TESTING.

**CONTINTUED ON BACK**