Wayne R. Kirkham, M.D.

DEPENDENT PATIENT FORM

DATE: _____

PATIENT'S NAME: _____ AGE: _____ BIRTHDATE: _____

PATIENT'S ADDRESS: _____ CITY: _____ STATE: _____

HOME TELEPHONE: _____ SEX: M F ZIP: _____

PATIENT INFORMATION

FATHER'S NAME: _____ MOTHER'S NAME: _____

ADDRESS: _____ ADDRESS: _____

_____ _____

HOME TELEPHONE: _____ HOME TELEPHONE: _____

WORK TELEPHONE: _____ WORK TELEPHONE: _____

CELL PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____ EMPLOYER ADDRESS: _____

_____ _____

BIRTHDATE: _____ BIRTHDATE: _____

Have we seen any members of your immediate family before? _____ Name(s): _____

_____

REFERRED BY: _____ ADDRESS (IF KNOWN): _____

_____ _____

INSURANCE INFORMATION

PRIMARY CARRIER

INSURANCE CO.: _____

ADDRESS: _____

PHONE NO.: _____

ID NO.: _____

POLICY/GROUP NO.: _____

INSURED'S NAME: _____

EMPLOYER: _____

SECONDARY CARRIER

INSURANCE CO.: _____

ADDRESS: _____

PHONE NO.: _____

ID NO.: _____

POLICY/GROUP NO.: _____

INSURED'S NAME: _____

EMPLOYER: _____

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Wayne R. Kirkham, M.D. Appointments not cancelled within 24 hours or "no show" appointments will be subject to a $65.00 charge. This charge is not covered or billable to your insurance company.

Signature (Patient or Parent): _____