Wayne R. Kirkham, M.D.

PATIENT INFORMATION

DATE: _____

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____

HOME TELEPHONE: _____ ZIP: _____

CELL PHONE: _____ WORK TELEPHONE: _____

MARITAL STATUS: S____M____D____W____ SEX: M____F____

EMPLOYER NAME: _____ OCCUPATION: _____

WORK ADDRESS: _____ CITY: _____ ZIP: _____

SPOUSE'S NAME: _____ SPOUSES' DATE OF BIRTH: _____

SPOUSE'S EMPLOYER: _____ PHONE: _____

WORK ADDRESS: _____ CITY: _____ ZIP: _____

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): _____