Kimberly Cockerham, MD

Patient Profile

Doctor: ____________________________

Patient Information:

Name:	____________________________	Date of Birth:	____________________________
Address	____________________________	Social Security #:	____________________________
	____________________________	Marital Status:	____________________________
City, State & Zip Code:	____________________________	Spouse/Partner Name:	____________________________
Home Phone:	(_______)_________________	Emergency Contact:	____________________________
Cell/work Phone:	(_______)_________________		____________________________
Email:	____________________________		____________________________

Employment Information: [ ] Employed [ ] Retired [ ] Unemployed [ ] Other

Employer:	____________________________	Work Phone:	(_______)_________________
Address	____________________________	Other Phone:	(_______)_________________
	____________________________		
City, State & Zip Code:	____________________________		

Insurance Information: [ ] Self [ ] Spouse [ ] Other

Primary Insurance:	____________________________	Insured Name:	____________________________
Insurance Address	____________________________	Insured Date of Birth:	____________________________
	____________________________	Insured SSN:	____________________________
City, State & Zip Code:	____________________________	Insured ID #:	____________________________
		Insured Group #:	____________________________
Insurance Phone:	(_______)_________________	Relationship to Primary Insured/Grantor:	____________________________

Secondary Insurance:	____________________________	Insured Name:	____________________________
Insurance Address	____________________________	Insured Date of Birth:	____________________________
	____________________________	Insured SSN:	____________________________
City, State & Zip Code:	____________________________	Insured ID #:	____________________________
		Insured Group #:	____________________________
Insurance Phone:	(_______)_________________	Relationship to Primary Insured/Grantor:	____________________________

Medical Information:

Referring Physician	____________________________		
Address	____________________________	Phone:	(_______)__________________
	____________________________	Fax:	(_______)__________________
City, State & Zip Code:	____________________________		

Primary Physician	____________________________		
Address	____________________________	Phone:	(_______)__________________
	____________________________	Fax:	(_______)__________________
City, State & Zip Code:	____________________________		

Other Physician	____________________________		
Address	____________________________	Phone:	(_______)__________________
	____________________________	Fax:	(_______)__________________
City, State & Zip Code:	____________________________		

I hereby request and consent to treatment for myself or my child at the office of Dr. Kimberly P. Cockerham.

Patient Name: Date:

I authorize the release of any medical records or other information necessary for the processing of medical claims for myself or on my child's behalf.

Patient Name: Date:

Authorization and Insurance Policy Guidelines

If you insurance requires an authorization from your primary care physician for a specialist services, please present it prior to your **first visit**.

The authorization should state that it covers the visual field tests needed for your consultation or visit.

You will be held liable if your insurance is not in effect on the date of service.

Secondary Insurance Billing: As a courtesy to you we will bill you secondary insurance. If your insurance fails to pay within 30 days of the primary payment, the balance will be forwarded to you for payment.

Appeals: I hereby consent for the office of Dr. Kimberley P. Cockerham to act on my be held in pursuing any insurance appeals, necessary to obtain payment for services rendered. I acknowledge that insurance appeal advocacy does not constitute legal representation, and that I may retain outside legal counsel to participate concurrently, if I so chose.

Please sign below to acknowledge that you have read and understand the above policies.

Thank You,