Warrett Kennard, M.D.

GENERAL & VASCULAR SURGERY | DIPLOMAR AMERICAN BOARD OF SURGERY | FELLOW AMERICAN COLLEGE OF SURGERY

Patient Information Form

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ SSN: _____ Preferred Language: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Ethnicity: _____(ex. Latino, None) **Race: _____**(ex. African Amer., Asian, Caucasian, Hispanic, Other)

Primary Care Physician (PCP): _____ PCP Phone Number: _____

Referring MD: _____ Referring MD Phone Number: _____

Referred by, if not a doctor: _____

Preferred Pharmacy: _____ Phone Number: _____

Employer: _____ Phone Number: _____ Occupation: _____

Employer Address: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Responsible Party if Different from Patient: _____ Relationship: _____

DOB: _____ SSN: _____ Phone Number: _____

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Do you have Medicare? Yes _____ No _____

Primary Insurance: _____ Name of Policy Holder: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Policy Number: _____ Group Number: _____

Claims Billing Address (located on back of card): _____

Secondary Insurance: _____ Name of Policy Holder: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Policy Number: _____ Group Number: _____

Claims Billing Address (located on back of card): _____

*****Please Provide Your Driver's License & Insurance Card*****

I understand that I am responsible for charges incurred for my medical treatment. I direct that medical benefits from my insurance policy be paid directly to Warrett Kennard, M.D., in consideration of services rendered up to the total amount of my account. I authorize Dr. Warrett Kennard to release information to my insurance company.

Signature: _____

Please fax completed forms to (972) 248-2493 before your appointment or bring them with you.