

Kimberly
Cockerham, MD



Kimberly Cockerham MD, FACS
Plastics-Orbit-Neuro-Ophthalmology

Patient Information

Name _____ Date of Birth _____ Age _____
last name first name m.i.

Address _____
Street apt# city state zip

Mailing Address _____
If different from above

Home Phone () _____ Business Phone () _____

Cell Phone () _____ Email Address _____

Social Security # _____ Status: S M D W Sex: M F

Occupation _____ Employer _____

Emergency Contact _____ Telephone # _____

Responsible Party if Patient is a Minor _____

Relationship _____ Date of Birth _____ SS# _____

Insurance Information

Primary Insurance Coverage

Secondary Insurance Coverage

Insurance Company _____

Subscriber Name _____

Subscriber I.D# _____

Relationship to Patient _____

Group or Policy # _____

Insured Date of Birth _____

Medical History

Reason for Consultation _____

Primary Care Physician _____ Address _____
street city state zip

Referred By _____ Specialty _____

Address _____ Phone () _____

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

Signature

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.

Signature

Date

Authorization and Insurance Policy Guidelines

If your 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 your secondary insurance. If your insurance fails to pay within 30 days of the primary payment, the balance will be forwarded to you.

Appeals: I hereby consent for the office of Dr. Kimberly Cockerham to act on my behalf 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.

Signature of Patient or Guardian

Date