# Mary C. Kerr, M.D., M.P.H.

**Please Print Clearly** **Please Fill Out Completely**

Name of Patient: _____ Age: _____ D.O.B: _____

Home Address: _____City: _____State: _____Zip: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

E Mail: _____ Social Security Number: _____

Married_____ Single_____ Widowed_____ Separated_____ Domestic Partner_____ Driver Lic #_____

Occupation: _____ Employer: _____

Business Address: _____ Phone: (___)_____

Emergency Contact: _____ Phone: (___)_____Relationship:_____

**Primary Insurance**
Insurance Company: _____ Subscriber's Name:_____

I.D. #: _____ Group #: _____ Phone #: _____

Claims Address: _____ City: _____ ST: _____ Zip: _____

Relationship to Patient:_____ Birth Date:_____ Social Security:_____

**Secondary Insurance**
Insurance Company: _____ Subscriber's Name:_____

ID #: _____ Group #: _____ Phone #: (___)_____

Claims Address: _____ City: _____ ST: _____ Zip: _____

Relationship to Patient: _____ Birth Date: _____ Social Security: _____

Primary Care Physician: _____Who referred you to Dr. Kerr? _____

Pharmacy Name:_____ Phone :_____

**I understand and agree that I am financially responsible for all charges for services performed by Mary C. Kerr, M.D., M.P.H.**

I hereby authorize my insurance carrier to release information regarding my medical benefits and payment under my policy directly to Mary Kerr, M.D., M.P.H.. If surgery is performed, I will authorize payment of insurance benefits to Mary C. Kerr, M.D., M.P.H.,UCLA Surgery Center or Linden Crest Surgery Center.
I have read and understand the HIPPA policy.

Notice to Consumers:
Medical doctors are licensed and regulated by the Medical Board of California.
800-633-2322 www.mbc.ca.gov

Signature of Patient:_____
Date:_____