

**Laurence Kirwan, MD, FRCS, FACS  
Consultant Plastic Surgeon**

**Patient Surname,** \_\_\_\_\_ **First Name,** \_\_\_\_\_ **Middle Initial,** \_\_\_\_\_  
**Age,** \_\_\_\_\_ **Date of Birth,** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Address,** \_\_\_\_\_ **PostalCode,** \_\_\_\_\_ **Country,** \_\_\_\_\_

**Phone Numbers**

**Business** (        ) \_\_\_\_\_ **Home** (        ) \_\_\_\_\_  
**Mobile** (        ) \_\_\_\_\_ **Fax** (        ) \_\_\_\_\_  
**E- mail** \_\_\_\_\_ @ \_\_\_\_\_

**Person responsible for payment**

**Surname,** \_\_\_\_\_ **First Name,** \_\_\_\_\_ **Middle Initial,** \_\_\_\_\_  
**Address,** \_\_\_\_\_ **Postal Code,** \_\_\_\_\_  
**Country,** \_\_\_\_\_

**Who referred you?** \_\_\_\_\_

**General Practitioner** \_\_\_\_\_ **Phone** (        ) \_\_\_\_\_

**Address,** \_\_\_\_\_

\_\_\_\_\_ **Postal Code,** \_\_\_\_\_

**Country,** \_\_\_\_\_

**Whom may we contact in the event of an emergency?**

**Surname,** \_\_\_\_\_, **First name,** \_\_\_\_\_, **Middle Initial,** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address,** \_\_\_\_\_ **Postal Code,** \_\_\_\_\_

**Payment at time of service cash, check or credit card.**

**I authorize Mr. Kirwan to disclose complete information concerning medical findings and treatment of the undersigned, from the initial office consultation until the date of conclusion of such treatment, to those individuals who, in Mr. Kirwan's sole determination are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review. A photocopy of this assignment is to be considered as valid as an original**

\_\_\_\_\_  
**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_  
**Parent's or Guardian's Signature ( if patient is under 16 years of age)** \_\_\_\_\_ **Date** \_\_\_\_\_