

Laurence Kirwan, M.D., F.R.C.S., F.A.C.S

Patient Surname, _____ **First Name,** _____ **Middle Initial,** _____

Age, ____ **Date of Birth, DD** ___/___/20___ **Today's Date,** ____D____M____Y

Address,
House Name/ Number, _____
Street _____
City, _____ **Postal Code,** _____
Country, _____

E- mail _____@_____

Phone Numbers:

Business () _____ **Home** () _____
Mobile () _____ **Fax** () _____

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 photograph 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** _____

Would you like us to send a letter to your general practitioner? Yes ___ No ___ **Initial** _____

We are unable to correspond with your General Practitioner without a complete postal address. Did you provide this information? Yes ___ No ___ **Initial** _____

Consent Form Provided ? Yes ___ No ___ **Initial** _____

(Mr. Kirwan Letter Dictated ___ G.P. ___ Patient ___)