Andrew H Kim DDS

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PATIENT REGISTRATION

DATE

PATIENT INFORMATION

PATIENT'S NAME Last_____ First_____ MI_____ PREFERRED NAME_____

ADDRESS: Street _____ Apt # _____

City_____ State_____ Zip _____

HOME NO_____ CELL NO_____ WORK NO_____

EMAIL_____@_____ SEX: M F STATUS: Minor Single Married Divorced Separated Widowed Partnership

BIRTHDATE:_____ AGE: _____ Soc. Sec. # _____ DRIVER LIC #_____

PREFERRED METHOD OF CONTACT: _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

Who May We Thank for Referring You to our Office? _____

Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____

RELATION TO PATIENT _____ SEX: M F STATUS: Single Married Divorced Widowed

SOCIAL SECURITY # _____ BIRTHDATE _____ DRIVER'S LICENSE # _____

MAILING ADDRESS Street _____ Apt # _____

City _____ State _____ Zip _____

HOW LONG AT THIS ADDRESS _____ HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL _____ @ _____

PREVIOUS ADDRESS (if less than 3 yrs.) Street _____ Apt # _____

City _____ State _____ Zip _____ How Long _____

EMPLOYER _____ OCCUPATION _____

NO. YEARS EMPLOYED _____

EMERGENCY INFORMATION: RELATIVE NOT LIVING WITH YOU.

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PH. _____ CELL PH. _____ WORK PH. _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co._____ PH #_____

Insurance Co. Address _____

Insured's Employer_____

Insured's Soc. Sec. #_____Group #_____

Insured's Member ID #_____Local # _____

OTHER DENTAL INSURANCE INFORMATION (Secondary Carrier)

Insured's Name _____

Insurance Co._____ PH # _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. #_____Group # _____

Insured's Member ID #_____ Local # _____

I assure the information on this page and the dental/medical history forms are correct to the best of my knowledge. I authorize Andrew H Kim DDS PC to utilize the information provided in conjunction with information collected utilizing diagnostic tools, not limited to radiographs, photographs, and diagnostic instruments, to diagnose, treatment plan, administer medications and treat oral disease necessary for proper dental care.

I authorize Andrew H Kim DDS PC to release any information pertaining to but not limited to dental/medical history, the records of examination, diagnosis, and treatment rendered to my self or my dependents during the period of such dental care, to third party payers and/or health professionals. I authorize and request my insurance company to pay directly to Andrew H Kim DDS PC insurance benefits otherwise payable to me.

Andrew H Kim DDS PC reserves rights to refer or decline services at our discretion.

PATIENT/GUARDIAN SIGNATURE: _____DATE:_____