CHRISTINE H. KIM, D.M.D.
Restorative, Cosmetic & Implant Dentistry

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PATIENT INFORMATION

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Name ______________________ SSN ______________________ Birthdate ____________

Address ______________________________ City ____________ State ______ Zip ________

Home Phone (_____) __________ Work Phone (_____) __________ Cell Phone/Pager (_____) __________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced

If Minor - Parent's Name ______________________________

Patient's or Parent's Employer ______________________________ Work Phone (_____) __________

If Patient is a Student, Name of School/College ______________________________

Whom May We thank for Referring You? ______________________________

Person to Contact in Case of Emergency ______________ Relation __________ Phone (_____) __________

RESPONSIBLE PARTY

Name of Person Responsible for this Account ______________________________ Relation to Patient ______________

Address ______________________________ Home Phone (_____) __________

Employer ______________________________ Work Phone (_____) __________

Currently a Patient in our Office? ☐ Yes ☐ No Cell Phone/Pager (_____) __________

PRIMARY INSURANCE INFORMATION

Name of Insured ______________________________ Relation to Patient ______________

Birthdate ______________ SSN ______________ Date Employed ______________

Employer ______________________________ Insurance Phone (_____) __________

Insurance Company __________ Group # ______________ Union or Local # ______________

Address ______________________________ City ____________ State ______ Zip ________

SECONDARY INSURANCE INFORMATION

Name of Insured ______________________________ Relation to Patient ______________

Birthdate ______________ SSN ______________ Date Employed ______________

Employer ______________________________ Insurance Phone (_____) __________

Insurance Company __________ Group # ______________ Union or Local # ______________

Address ______________________________ City ____________ State ______ Zip ________

RELEASE

- I authorize Payment of insurance benefits directly to Dr. Kim.
- I understand that I assume the ultimate responsibility for payment of services.
- There is a fee for all broken appointments without 24hr notice.

PATIENT'S OR GUARDIAN'S SIGNATURE ______________________________ DATE ______________