Christy Kim DDS

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Patient Information ***(CONFIDENTIAL)***

Name_____ M____ F____ Birth Date_____

SS#_____ Check Appropriate Status: Single____ Married____ Minor____

Address_____ City_____ State/Zip_____

Home #_____Cell #_____Work #_____

Hobbies_____ Drivers License #_____State____

Employer_____ Email _____

Spouse or Parent/Guardian's Name_____ Phone_____

Whom May We Thank for Referring You?_____

Person To Contact in Case of Emergency?_____ Phone_____

Person responsible for account balance?_____Phone_____

Insurance Information ***(Please show proof of ID with Insurance card.)***

Name of Subscriber: (insured employee)_____ Birth Date_____

Relationship to Patient_____ SS#_____

Employer_____ Work Phone_____

Insurance Company_____Phone # _____

Subscriber ID _____ Policy/Group #_____

Insurance Address_____

Do you have additional insurance? Yes___ No___ Secondary Information:_____

****Please read and initial**.

_____ I request and authorize Dr. Christy Kim to provide me and my children, with dental care.

_____As a condition of treatment by this office, I understand that me or my family member's financial responsibility will be given as an ***estimate*****,** prior to treatment.

_____**Assignment of Insurance**: I hereby authorize Dr. Christy Kim to bill my insurance company directly, and to release necessary information to process dental claims on my behalf. I understand that every attempt will be made to collect payment, on my behalf, from my insurance company. I know that I am ultimately responsible for any unpaid balance on my account, for myself and my children, regardless of my marital status. I understand balances over 90 days will be placed in collection status.

_____I understand that Dr. Christy Kim requires **48 hour notice** if I need to change my scheduled appointment, and that I must confirm my appointment 48 hours prior to my appointment time and date or I risk losing my appointment to another patient in need.

_____I understand that I will be charged a **$75 fee** for failing to show for a scheduled appointment, unless there is an event of an emergency.

Signature_____ Date_____