



Patient Registration

Patient Information

Name _____ Birth date _____ Sex M / F Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Soc Sec# _____

Check Appropriate Box Minor Single Married Divorced Widowed If student, F.T. P.T.

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____ May we call you at work? Y N

Person to Contact in Case of Emergency _____

Name of Person Responsible for this Account _____ Relationship to patient _____

Insurance Information

Name of Insured _____

Relationship to patient _____

Birth date _____ Soc Sec # _____

Name of Employer _____

Union/local# _____ Insurance Phone _____

Insurance Company _____

Group # _____ Policy/ID # _____

Do you have additional insurance?

Name of Insured _____

Relationship to patient _____

Birth date _____ Soc Sec # _____

Name of Employer _____

Union/local# _____ Insurance Phone _____

Insurance Company _____

Group # _____ Policy/ID # _____

CONSENT:

I consent to the diagnostic procedures and treatment by Dr. Kim necessary for proper dental care.

I consent to Dr. Kim's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payments.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care: Insurance Companies, Claim Administrators, Referring and Consulting Health Care Professionals.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to Vista Dental of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE: _____ DATE: _____