Patient Registration

Personal Information

Name: _____
First Last Middle Initial

Date of Birth: ____/___/____ Sex: M/F SS#: _____

Address: _____

_____

□ Single □ Married □ Divorced □ Widowed

Phone Numbers: Home:_____
Work: _____
Cell: _____

Emergency Contact & Phone Number: _____

Insurance Information

□ Private (not participating in any dental insurance plans)

□ Dental Insurance

Insured's Name: _____
Insured's Date of Birth: _____
Insured's Social Security Number: _____
Relationship to Patient: _____
Insurance Company: _____
Employer: _____
Group #/Subscriber ID: _____

Assignment and Release (for patients participating in dental insurance only)

I certify that I, and/or my dependent(s), have dental insurance coverage with the insurance company(ies) named above and assign directly to Dr. Daniel J. Kim (Ramsey Dental, P.C.) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for notifying Dr. Daniel J. Kim (Ramsey Dental, P.C.) of any changes in insurance coverage. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Daniel J. Kim (Ramsey Dental, P.C.) may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Date Signature of Patient / Legal Guardian (relationship)