Issaquah Smile Designs

Eun H. Kim, D.D.S., P.S.

Patient Information

Name: ____ Date: ____________________

First Middle Last

Address: ______________________________ City: ______________ State: ______ Zip: ________________

E-mail: ____

Home Phone #: ________________ Work Phone #: ________________ Cell #: ____________________

Sex: M / F Age: ________ Birthday: _____/_____/_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employed By: ____________________________________ Occupation: ____________________

Spouse/Parent Employed By: ____________________________ Work Phone #: ____________________

Person to contact in case of emergency: __________________________ Phone #: ____________________

Relationship to Patient: ____________________ Whom may we thank for referring you: ____________________

Responsible Party

Name of person responsible for this account: ____

Relationship to Patient: ____________________________________ Phone #: ____________________

Address: ______________________________ City: ______________ State: ______ Zip: ________________

Name of Employer: ______________________________________ Work Phone#: ________________

Insurance Information

Primary

Name of Insured: ____________________________

Name of Insurance Company: ____________________________

Relationship to Patient: ____________________________

Employer: ____________________________

DOB: ____________ ID#: ________________

SSN: ____________________________

GP#: ____________________________

Secondary

Name of Insured: ____________________________

Name of Insurance Company: ____________________________

Relationship to Patient: ____________________________

Employer: ____________________________

DOB: ____________ ID#: ________________

SSN: ____________________________

GP#: ____________________________

Assignment & Release: I authorize the dentist or insurance company to release any information required for payment or review of this claim. I hereby authorize my insurance benefits to be paid directly to the dentist and I understand that I am financially responsible for any balance due.

Patient or Parent's Signature: ____

Financial Agreement: The undersigned Patient or Responsible Party agrees that the following terms will govern the payment of professional services rendered by the Doctor and charged to his account.

1. All patient portions are due at the time of service.
    1. The Patient agrees to pay the balance of account in full within 30 days of the billing date.
    2. In the event Patient fails to pay the balance within 30 days of the billing date, a finance charge of 1% per month shall be assessed.
    3. The Doctor may refuse to render services until the amount outstanding has been pain in full.
    4. Checks returned from the Bank insufficient funds will be subject to a charge.
    5. A fee will be charged for a missed appointment or appointments cancelled with less than a 48 hour notice.

The undersigned Patient or Responsible Party understand and agrees to the financial policy indicated above.

____________________ ______________________________________

Date Patient or Responsible Party's Signature