Hyunsoo Lim DDS
Patient Registration

Patient Information

Patient_____
Address_____
City_____State_____Zip_____

Sex: □M □F Age_____ DOB_____
□Single □Married □Widowed □Divorced
Patient/Guardian SSN_____
Occupation_____
Employer_____
Spouse's Name_____
DOB_____SS#_____
Employer_____
Whom may we thank for referring you?_____

Phone Numbers:
Cell_____Cell Carrier(text)_____
Home_____Work_____
Email_____
Reminder via:( )Home ( )Cell ( )Work ( )Text ( )Email
Emergency contact_____
Relationship to you_____
Home_____Cell_____

Financial Responsibility/Dental Insurance

Subscriber_____
DOB_____Relationship to patient_____
Ins ID# or SS#_____
Insurance Co._____Group#_____
Ins. Phone_____Employer_____
Is patient covered by other insurance? No ( ) Yes ( ) If Yes:
Subscriber_____
DOB_____Relationship to patient_____
INS ID# or SS#_____
Insurance Co._____Group#_____
Ins. Phone_____Employer_____

Assignment and Release

I certify that I (or my dependent) have insurance coverage and assign directly to Hyunsoo Lim, DDS all insurance benefits, if any, for services rendered. *I understand that I am financially responsible for all charges whether or not paid by insurance.* I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____
Relationship Date

Acknowledgement of Privacy Practices and Cancellation Policy

I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of Hyunsoo Lim, DDS. The Statement of Privacy Practices describes uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office healthcare operations. The posted Statement of Privacy Practices describes my rights and the responsibilities of this office with respect to my protected health information.

Hyunsoo Lim, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If changes occur I will be offered a revised copy at the first visit after the revision is made.

Additional Disclosure

In addition to the allowable disclosures described I authorize disclosure of my protected health information to the persons indicated below.

□ Any member of my immediate family □ Spouse only □ Other_____

Print Patient Name_____Patient Signature_____

Guardian Signature if Minor_____

This office has a 48 business hour cancellation policy. If you miss or late cancel your scheduled dental appointment you will be charged a $90 fee per appointment.

Signature_____Relationship_____Date_____