WELCOME TO OUR OFFICE

Joseph J. Kim, D.D.S. P.S.

Family Dentistry

ABOUT YOU

Today's Date: ____/____/________

Name: ______________________________________
Last First MI

I prefer to be called: ____________________ ☐ Male ☐ Female

Birthdate: ____/____/_____ Age: _____ SS#:______-_____-________

Home Address:____________________________________
Appt/Condo#

____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Separated

Hm#: (_____)________________ pager/cell#: (_____) ____________

Wk#:(_____)________________ e-mail:______________________

Emergency contact name:__________ phone#: (_____) __________

Person Responsible for Account: __________________

Wk#:(______)__________ Ext: ______ Hm#: (_____)__________

Billing Address: ________________________________

____

Employer: ____________________________________

How long there? __________ Occupation: ________________

Previous/Present Dentist:______________________
(please circle)
Last visit date: ____________________________________

Whom may we Thank for referring you? __________________

SPOUSE INFORMATION

His/Her Name: ________________________________

Employer: ____________________________________

Wk#: (______)______________ Ext:________

Birthdate: ____/_____/________ SS#: _______-______-__________

INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ____________________________

Insurance Co. Phone#: (______)______________________

Group # (Plan, Local or Policy#) ____________________

Insured's Name: ______________ Relation:___________

Insured's Birthdate: ____/____/_____ SS#:______-______-______

Insured's Employer: ______________________________

Employer's Address: ______________________________

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ____________________________

Insurance Co. Phone#:(______)______________________

Group # (Plan, Local or Policy#) ____________________

Insured's Name: ______________ Relation: ___________

Insured's Birthdate: ____/____/_____ SS#:______-______-______

Insured's Employer: ______________________________

Employer's Address: ______________________________

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ________________________________

Phone#: (_____)______________ Date of last visit ___________

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: __________________________________

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