

# WELCOME

## PATIENT INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ ext \_\_\_\_\_ (Cell) \_\_\_\_\_

Email address \_\_\_\_\_  Male  Female

Minor (under 18 yrs old)  Single  Married  Widowed  Separated  Divorced

Social Security #: \_\_\_\_\_ Employer (if minor, Parent's Employer): \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Why did you choose our office? \_\_\_\_\_

In case of emergency, contact (someone who does not live in your household)

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

## RESPONSIBLE PARTY

Who will be paying the bill? \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I understand that I am financially responsible for all charges incurred. In the event that my account is placed with a third party collection agency or attorney, I will be assessed any fees relating to this action.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## Primary Insurance Information

Subscriber's Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_ Phone#: \_\_\_\_\_

## Secondary Insurance Information

Subscriber's Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_ Phone#: \_\_\_\_\_

I certify that I (or my dependent) have insurance coverage, and assign directly to Dr. James J. Hur DDDS all insurance benefits, if any, for services rendered. I understand that if my insurance company fails to pay **for any reason**, I am financially responsible for all charges incurred. In the event that my account is placed with a third party collection agency or attorney, I will be assessed any fees relating to this action. I hereby 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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_