REGISTRATION

(PLEASE PRINT)

JOSEPH D.LIM, D.M.D.

3510 Torrance Blvd. Suite #303
Torrance, CA 90503
(310) 540-8780

Date_____ Home Phone(____)_____Cell Phone(____)_____ Email_____

PATIENT INFORMATION

Name_____Social Security #_____
Last Name First Name Middle Initial

Address_____ Driver's license #_____

City_____State_____ZIP_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐Married ☐Divorced ☐ Single ☐ Minor ☐Separated ☐ Widowed ☐ Partnered

Patient Employer/ School_____Occupation_____

Employer/School Address_____Employer/School Phone(____)_____

How did you hear about us?_____

In case of emergency who should be notified?_____Phone(____)_____

PRIAMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Middle Initial

Relationship to Patient_____ Birthdate_____

Address(If different from patient's)_____ Phone(____)_____

City_____ State_____Zip_____

Person Responsible Employed by_____ Occupation_____

Business Address_____ Business Phone(____)_____

Insurance Company_____

Group #_____Subscriber #_____Soc.Sec #/ID #_____

Namee of other dependents covered under this plan_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____Birthdate_____ Relationship to patient_____

Address(If different from patient's)_____ Phone(____)_____

City_____ State_____Zip_____

Subscriber Employed by_____Business Phone(___)_____

Insurance Company_____

Group #_____Subscriber #_____Soc.Sec #/ID #_____

Namee of other dependents covered under this plan_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have Insurance coverage with _____and assign directly to
Name of Insurance Company(ies)

JOSEPH D. LIM, D.M.D. all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance information. The above-named dentist 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.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient