

REGISTRATION

(PLEASE PRINT)

JOSEPH D.LIM, D.M.D.

2430 Torrance Blvd # A
Torrance, CA 90503
(424) 318-2048

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(____) _____

PRIMARY 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 # _____
Name 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 # _____
Name 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