PATIENT INFORMATION SHEET

DAVID H KIM, M.D.
17742 BEACH BLVD STE 245
HUNTINGTON BCH, CA 92647
(714) 848-1911

PATIENT INFORMATION

ACCOUNT NO

PATIENT NAME

Address

Address (cont'd)

City | State | Zip

Home Phone | Work | Ext | Cell

Sex
Male Female

Birth Date | Age

SSN | Driver's License

Marital Status
Single Married Widowed Divorced Separated

INJURY INFORMATION (MUST BE COMPLETED)

LIST BODY PART TO BE EXAMINED: RIGHT LEFT

DATE of INJURY or ACCIDENT:
(REQUIRED by your Insurance) mm dd yy

WERE YOU INJURED ON THE JOB?
YES NO

WAS THIS AN AUTOMOBILE ACCIDENT?
YES NO

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name

Address

City | State | Zip

Relationship to Patient (Self,Spouse,Parent,Other)

Phone | SSN

PATIENTS EMPLOYER INFORMATION
(If the patient is a minor list the insureds employer)

Company Name

Address

City | State | Zip

Occupation | Self-Employed

Work Phone

INSURANCE COMPANY INFORMATION

1. PRIMARY INSURANCE COMPANY NAME

Address

City | State | Zip

Policy Holders Date of Birth | Relationship to Patient: CIRCLE ONE
Self Husband Wife Father Mother Other

ID Number of Policy Holder REQUIRED | Group Number

2. SECONDARY INSURANCE COMPANY NAME

Address

City | State | Zip

Policy Holders Birth Date | Relationship to Patient

ID Number of Policy Holder REQUIRED | Group Number

SPOUSE INFORMATION

Full Name

Birth Date

SSN

Employer

NEAREST RELATIVE

Name

Address

City | State | Zip

Phone | Relationship to Patient

Referred by **Phone# ( )**
1. Doctor

2. Previous Patient of Doctor you are seeing today: Yes No

LIST ANY ALLERGIES

1. 2.

3. 4.

Insurance Authorization and Assignment:
I hereby authorize physician listed above to furnish information to carriers concerning my illness, injury and treatment.
I hereby assign to the physician all payments for medical services rendered to myself or my dependents.
I understand that I am responsible for any amount not covered by my insurance.

SIGNATURE | DATE