PATIENT INFORMATION SHEET

DAVID H KIM MD INC
19582 BEACH BLVD STE 120
HUNTINGTON BCH, CA 92648-2996
(714) 848-1911

PATIENT INFORMATION	ACCOUNT NO
PATIENT NAME	
Address	
Address (cont'd)	
City	State / Zip
Email Address	
Primary Phone / Secondary Phone	
Sex (Male Female) / Birth Date / Age	
SSN / Driver's License	
Marital Status (Single Married Widowed Divorced Separated)	

REASON FOR VISIT (MUST BE COMPLETED)
List BODY PART to be EXAMINED:
DATE of onset of PAIN OR INJURY: (REQUIRED by Insurance) mm dd yy
WERE YOU INJURED ON THE JOB? YES NO
WAS THIS AN AUTOMOBILE ACCIDENT? YES NO

POLICY HOLDERS INFO IF DIFFERENT THAN PATIENT ***SPOUSE & DEPENDENTS UNDER 26 MUST FILL OUT***
Name
Address
City / State / Zip
Relation to Patient CIRCLE ONE (Father,Mother,Husband,Wife,Other) Insureds DATE OF BIRTH
Phone / SSN

INSUREDS EMPLOYER INFORMATION (If the patient is a dependent list the subscribers employer)
Company Name
Address / State / Zip
City / Self-Employed
Occupation

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

PHARMACY INFORMATION
PHARMACY NAME
Address
Phone

NEAREST RELATIVE
Name
Relationship / Phone
Address
City / State / Zip

REFERRING PHYSICIAN
Doctor: / Phone
Are you a Previous Patient of the 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