**Issaquah Smile Designs**
**Eun H. Kim, D.D.S., P.S.**

## Patient Information

Name: ______________________________________________ Date: ____________________
*First* *Middle* *Last*
Address: ____________________________ City: ____________ State: _____ Zip: ______________
E-mail: ______________________________________________________________________
Home Phone #: ________________ Work Phone #: _________________ Cell #: _____________________
Sex: M / F Age: _______ Birthday: ____/____/____ Single Married Widowed Separated Divorced
Employed By: ______________________________________ Occupation: _______________________
Spouse/Parent Employed By: ____________________________ Work Phone #: _______________________
Person to contact in case of emergency: __________________________ Phone #: ____________________
Relationship to Patient: ____________________ Whom may we thank for referring you: ______________________

## Responsible Party

Name of person responsible for this account: _____________________________________________________
Relationship to Patient: __________________________________ Phone #: ______________________
Address: ______________________________ City: ____________ State: _____ Zip: ______________
Name of Employer: ________________________________________ Work Phone#: __________________

## Insurance Information

*Primary*

Name of Insured: ___________________________
Name of Insurance Company: ___________________
Relationship to Patient: _______________________
Employer: ______________________________
DOB: ____________ ID#: _________________
SSN: __________________________________

*Secondary*

Name of Insured: ___________________________
Name of Insurance Company: ___________________
Relationship to Patient: _______________________
Employer: ______________________________
DOB: ____________ ID#: _________________
SSN: __________________________________

**Assignment & Release**: I authorize the dentist or insurance company to release any information required for payment or review of this claim. I hereby authorize my insurance benefits to be paid directly to the dentist and I understand that I am financially responsible for any balance due.
**Patient or Parent's Signature**: ________________________________________________________

**Financial Agreement**: The undersigned Patient or Responsible Party agrees that the following terms will govern the payment of professional services rendered by the Doctor and charged to his account.

1. **All patient portions are due at the time of service**.
1. The Patient agrees to pay the balance of account in full within 30 days of the billing date.
2. In the event Patient fails to pay the balance within 30 days of the billing date, a finance charge of 1% per month shall be assessed.
3. The Doctor may refuse to render services until the amount outstanding has been pain in full.
4. Checks returned from the Bank insufficient funds will be subject to a charge.
5. A fee will be charged for a missed appointment or appointments cancelled with less than a 48 hour notice.

**The undersigned Patient or Responsible Party understand and agrees to the financial policy indicated above**.

___________________________ ________________________________________
Date Patient or Responsible Party's Signature