

KIMCHE COSMETIC & SPORTS DENTISTRY
2921 PIEDMONT RD. SUITE E
ATLANTA GA., 30305
(404) 262-0806

Patient's name: _____
Patient's address: _____
Apt.# _____ City: _____ State: _____ Zip: _____
Home phone#: _____ Work#: _____
Cell#: _____ e-mail address: _____
SSN: _____ Date of birth: _____
Age: _____ Gender: _____ Marital Status: _____

Employer Name: _____ Occupation: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Whom may we thank for referring you ? _____
Person to contact in case of an emergency? _____
Address: _____
Phone#: _____ Relationship: _____

Do you have dental insurance? Yes No
Name of employer supplying dental insurance: _____
Insured employee name: _____
Employee SSN: _____ Date of Birth: _____

Primary Dental Insurance Company Name: _____
Claim filing address: _____
City: _____ State: _____ Zip: _____
Group#: _____ Policy# _____
Payor ID# _____ Phone#: _____

Assignment of benefits: I here by state that I am financially responsible for my account and I authorize my insurance benefits (if any) to be paid directly to the Dentist (if applicable). I also authorize the Dentist to release any requested information to my insurance company. I understand that if my account is referred to a collection agency that an amount not to exceed 35% of the balance plus court/collection costs will be applied. If I need to cancel or reschedule an appointment I will give 24 hours notice or I will be charged a broken appointment fee.

Signature: _____ Date: _____