PACIFIC MODERN DENTISTRY

Jae Seon Kim DDS,MSD,FACP
2046 Westlake Ave N, Suite 204
Seattle, WA, 98109
206.284.4505
info@pacificmoderndentistry.com
www.pacificmoderndentistry.com

Patient Information Sheet

Patient's Name: Last: _____ First: _____ Birthdate: _____
Patient Mailing Address: _____
City_____State_____Zip_____
Social Security #: _____ Email Address: _____@_____
Home Phone: _____ Work Phone: _____Cell Phone: _____
Spouse's Name: Last: _____ First: _____ Birthdate_____
Primary Phone: _____ Email Address: _____@_____
Emergency Contact Name: _____Phone: _____
Who can we thank for referring you or How did you find out office? _____
Last Name: _____ First Name: _____

Insurance Information

Primary:
Insurance Name: _____ Phone Number: _____
Mailing Address: _____ Payer ID: _____
Subscriber's Name: Last: _____ First: _____ Birthdate: _____
Relationship to patient: Self Spouse Dependent Other Subscriber's ID #:_____
Employer/ Company Name: _____ Group #: _____
Secondary:
Insurance Name: _____ Phone Number: _____
Mailing Address: _____ Payer ID: _____
Subscriber's Name: Last: _____ First: _____ Birthdate: _____
Relationship to patient: Self Spouse Dependent Other Subscriber's ID #:_____
Employer/ Company Name: _____ Group #: _____

Acknowledgement of Privacy Practice

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's Notice of Privacy Practices as required by the Health Insurance Portability & Accountability Act of 1996. I understand that this information can and will be used to: provide and coordinate treatment among health care providers who may be involved in my care, obtain payment from third-party payers for health care services and conduct normal health care operations. Dependent family members are also covered by this acknowledgement.
I authorize the release of information to the following:
Last, First Name: _____Contact Number: _____
Last, First Name: _____Contact Number: _____

Assignment & Release

I hereby authorize my insurance benefits to be paid to the dentist. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy. I consent to the making of videotapes, photographs, and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Financial Policy

Without Insurance: Fees are paid at the time of service. Fees may be paid with cash, check, Visa, MasterCard or Care Credit. When paying in full with cash or check there is a 5% discount of the fee.

With Insurance: Please contact your insurance company or your Human Resource representative directly to learn about the policies regarding your benefits. Our office will submit claims and communicate with the insurance company on your behalf about the treatment and services we provide.

Please note: Our office is unable to guarantee the fee schedule used by your insurance company and we are not responsible for decisions about your claims and/or any misinformation from your insurance company about your benefits. You are responsible for any balance on your account.

We ask that you assign your insurance benefits to our office. If, however, your insurance company pays you directly your financial arrangement will be handled in the same manner as those without insurance. Your patient portion (co-pay) is due at the time of service.

Statement: Our office sends out monthly statements to our patients to keep them aware of all activity on their account during the last 30 days. All account balances outstanding more than 60 days from the service date will bear interest at 1.5% per month or 18% per year.

Missed Appointments & Late Cancellations: We request that you notify our office at least 2 of our business days in advance if you are unable to keep your scheduled appointment. Our office charges a $75.00 fee when this notice is not given.

Photo Release

I hereby grant Jae Seon Kim DDS MSD PLLC, a Washington professional limited liability company ("Company"), and Jae Seon Kim, D.D.S., M.S.D., individually and as sole member of Company ("Dr. Kim") (collectively referred to as "Kim"), the irrevocable right and permission to use a photograph, in which I am readily identifiable, in any and all of Kim's publications, including but not limited to all printed and digital publications, websites, promotional flyers, or for any other similar purpose. I understand and agree that I will not receive any payment or other consideration for the use of said photograph.

I understand and agree that any photograph used for such purpose in which I am readily identifiable will become property of Kim and will not be returned. I hereby irrevocably authorize Kim to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing Kim's programs or for any other lawful purposes. I waive the right to inspect or approve the finished product. Additionally, I waive any right to royalties or other compensation arising from or related to the use of the photograph.

I hereby hold harmless, release and forever discharge Kim, his heirs, assigns, and personal representatives from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have in connection with the use or distribution of said photograph, including but not limited to any claims for invasion of privacy, infringement of personality rights under RCW 63.60, or defamation.

I warrant that I am at least 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release. This release is binding on me and my heirs, assigns, and personal representatives.

I have read and understood the above information:

Signature: _____ Date: _____