



MISUN KANG, D.M.D.
DOYLE VAN BUREN, D.M.D.

WELCOME TO OUR PRACTICE

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1) ABOUT YOU, THE PATIENT

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____

ZIP: _____ D.O.B.: _____

HM PHONE: _____ WK#: _____

CELL#: _____ EMAIL: _____

SS#: _____ MALE/FEMALE _____

EMPLOYER: _____

HOW LONG THERE? _____

MARRIED/SINGLE? _____

2) PERSON RESPONSIBLE FOR PAYMENT?

PAYMENT METHOD: *CASH* *CREDIT CARD*

RELATIONSHIP TO PATIENT: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____

ZIP: _____ D.O.B.: _____

HM PHONE: _____ WK#: _____

3) INSURANCE COVERAGE

INS. CO. NAME: _____

INS. CO. ADDRESS: _____

INS. CO. PHONE#: _____

GROUP# (PLAN, OR POLICY#) _____

INSURED'S NAME: _____

D.O.B.: _____ SS#: _____

EMPLOYER: _____

SECONDARY INSURANCE?

INS. CO. NAME: _____

INS. CO. ADDRESS: _____

INS. CO. PHONE#: _____

GROUP# (PLAN, OR POLICY#) _____

INSURED'S NAME: _____

D.O.B.: _____ SS#: _____

EMERGENCY CONTACT:

NAME: _____

PHONE#: _____ WK#: _____

Whom may we thank for referring you to our office? _____

I Hereby authorize the release of any information relating to claims, and payment of insurance benefits directly to Misun Kang, D.M.D

Signed _____ Date _____