

Patient Intake Form

Practice Information

Chong U. Kim, MD. Inc.
23430 Hawthorne Blvd. Suite 325
Torrance, CA 90505
Office (310) 705-8323
Fax (310) 683-6321
www.drchongkim.com

Personal Information

Patient Information

Last Name _____ First Name _____
Address _____

City _____ State _____ Zip _____
Email _____
Phone () - _____ SSN _____ - - _____
Mobile () - _____ Age _____
DOB / / _____ Marriage M S D W

Employment

Employer _____
Occupation _____ Years _____
Address _____

City _____ State _____ Zip _____
Email _____
Phone () - _____
Fax () - _____

Warning: This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that dissemination, distribution or copying of this information is strictly forbidden. If you have received this message in error, please notify us immediately and destroy this message.

Doctor Information

Primary Doctor

Doctor Name _____ Years _____

Address _____

City _____ State _____ Zip _____

Email _____

Phone () - _____

Fax () - _____

Referral

Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Phone () - _____

Mobile () - _____

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Spouse, Parent, or Guardian Information

Spouse, Parent, or Guardian

Last Name _____ First Name _____
Address _____

City _____ State _____ Zip _____
Email _____
Phone (____) - _____ SSN _____ - - _____
Mobile (____) - _____ Age _____
DOB ____ / ____ / ____ Marriage M S D W

Spouse, Parent, or Guardian Employment

Employer _____
Occupation _____ Years _____
Address _____

City _____ State _____ Zip _____
Email _____
Phone (____) - _____
Fax (____) - _____

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Primary Insurance Information

Primary Insurance Company

Address _____

City _____ State _____ Zip _____

Primary Insurance Policyholder

Last Name _____ First Name _____
Address _____

Patient Relation _____
City _____ State _____ Zip _____
Email _____
Phone () - _____ Policy No. _____
Mobile () - _____ Group No. _____
DOB / / _____ ID No. _____

Primary Insurance Policyholder Employer

Employer _____
Occupation _____ Years _____
Address _____

City _____ State _____ Zip _____
Email _____
Phone () - _____
Fax () - _____

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Other Insurance Information

Other Insurance Company

Address _____

City _____ State _____ Zip _____

Other Insurance Policyholder

Last Name _____ First Name _____
Address _____

Patient Relation _____
City _____ State _____ Zip _____
Email _____
Phone (____) - _____ Policy No. _____
Mobile (____) - _____ Group No. _____
DOB ____ / ____ / ____ ID No. _____

Other Insurance Policyholder Employer

Employer _____
Occupation _____ Years _____
Address _____

City _____ State _____ Zip _____
Email _____
Phone (____) - _____
Fax (____) - _____

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Authorization and Signature

Authorization to Release Information and Assignment of Benefits

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary.

I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

Signature _____

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