DENNIS H. KIM, M.D.
STEPHEN J. KORNFELD, M.D., FAAAAI, FACAAI
34041 U.S. HIGHWAY 19 NORTH, SUITE D, PALM HARBOR, FL. 34684

MINOR INFORMATION: ***Please use black or blue ink.***

Patient Name: _____Age: _____Date of Birth: _____Sex: M F

Address (local): _____City: _____State: ____Zip Code: _____

Home Phone: _____School Attending: _____Social Security #: _____

PARENT/GUARDIAN INFORMATION:

Mother: _____Social Security #: _____Cell # and/or E-mail:_____
Address (if different from above): _____Home phone:_____
Employer: _____Occupation: _____Work Phone:_____
Father: _____Social Security #: _____Cell # and/or E-mail:_____
Address (if different from above): _____Home Phone: _____
Employer: _____Occupation: _____Work Phone: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ Phone: _____

Mailing Address: _____

Policyholder: _____ Date of Birth: _____ Relationship to Patient: _____

Policy #: _____Group #:_____

SECONDARY INSURANCE INFORMATION: Do you have other insurance coverage? Yes ( ) No ( )

Insurance Company: _____Phone: _____

Mailing Address: _____

Policyholder: _____ Date of Birth: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____Employer:_____

OTHER MISCELLANEOUS INFORMATION:

Referred by: *Doctor ( ) *Family ( ) *Friend ( ) Phone Book ( ) Insurance Book ( ) Other ( )_____

*Please give full name and address:_____

Family Physician (PCP): _____Phone:_____

(Physician's Full Name)

_____

Do you have other family members who are patients in our office?(Name)_____ Relationship:_____

FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, AND RELEASE OF PROTECTED HEALTH INFORMATION

- I hereby agree to pay **DENNIS H. KIM, M.D., LLC** for all charges (to include co-pays, deductible and co-insurance amounts) at the time of service. I understand that although the office may accept assignment of insurance benefits, the charges ultimately are my responsibility. I realize that if a balance is due necessitating the use of a collection agency, I agree to pay all collection costs, including attorney fees.
- I authorize **DENNIS H. KIM, M.D., LLC** to file insurance claims on my behalf to the company(ies) with whom I have coverage to include the Social Security Administration. I authorize payment to be made to **DENNIS H. KIM, M.D., LLC** for services rendered to me.
- I consent to the release of protected health information which may be necessary to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.
- I accept responsibility for valuables brought to the office.
- I acknowledge that I have received a copy of **DENNIS H. KIM, M.D., LLC** Health Insurance Portability & Accountability Act (HIPAA) Notice of Privacy Practices.

Parent/Guardian Signature: _____ Date:_____