

**PETER KIM, M.D.
JO SANTAMINA, M.D.**

PATIENT INFORMATION

PATIENT (LAST) _____ (FIRST) _____ (MI) _____
ADDRESS (PLEASE NO P.O. BOX) _____ DOB _____
CITY, STATE, ZIP _____ MALE _____ FEMALE _____
HOME PHONE _____ CELL _____ WORK _____ S.S. # _____
MARITAL STATUS _____ SINGLE _____ MARRIED _____ DIVORCED _____ SEPARATED _____ WIDOWED
EMPLOYER NAME _____ OCCUPATION _____
ADDRESS _____ PHONE _____
CITY, STATE, ZIP _____
REFERRING PHYSICIAN _____ PHONE _____
OR REFERED BY: _____ FAMILY _____ FRIEND _____ CLOSE TO HOME/WORK _____ YELLOW PAGES _____ INTERNET _____ OTHER _____
EMERGENCY CONTACT _____ RELATION _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE NAME _____ RELATIONSHIP TO SUBSCRIBER: SELF _____ SPOUSE _____ CHILD _____
SUBSCRIBER (LAST) _____ (FIRST) _____ (MI) _____
DOB _____ GENDER: MALE _____ FEMALE _____
ADDRESS (PLEASE NO P.O. BOX) _____
CITY, STATE, ZIP _____
HOME PHONE _____ CELL _____ WORK _____ S.S. # _____
EMPLOYER NAME _____ OCCUPATION _____
EMPLOYER ADDRESS _____

SECONDARY INSURANCE

INSURANCE NAME _____ RELATIONSHIP TO SUBSCRIBER: SELF _____ SPOUSE _____ CHILD _____
SUBSCRIBER (LAST) _____ (FIRST) _____ (MI) _____
DOB _____ GENDER: MALE _____ FEMALE _____
ADDRESS (PLEASE NO P.O. BOX) _____
CITY, STATE, ZIP _____
HOME PHONE _____ CELL _____ WORK _____ S.S. # _____
EMPLOYER NAME _____ OCCUPATION _____
EMPLOYER ADDRESS _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and also authorize **Peter K. Kim MD or Jo Santamina, MD** to release any information required to process my claims. I understand that I am financially responsible for any balances or charges not covered by my insurance company.

Patient/ Guardian signature _____ Date _____