PETER KIM, M.D.
NEUROCARE NEUROLOGY

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 (PLEASE CIRCLE): SINGLE MARRIED SEPERATED WIDOWED OTHER, Email:_____

PREFERRED LANGUAGE (PLEASE CIRCLE) : ENGLISH SPANISH OTHER (SPECIFY_____)

RACE: DECLINE TO DISCLOSE, WHITE, BLACK/AFRICAN AMERICAN, ASIAN, AMERICAN INDIAN, OTHER (SPECIFY_____)

ETHNICITY: DECLINE TO DISCLOSE, CUBAN, HISPANIC, NOT HISPANIC, PUERTO RICAN, UNKNOWN, OTHER (SPECIFY_____)

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 ☐ CHECK THIS BOX IF INFORMATION IS THE SAME AS ABOVE

INSURANCE NAME _____ RELATIONSHIP TO SUBSCRIBER: SELF ___ SPOUSE ___ CHILD ___

SUBSCRIBER (LAST) _____ (FIRST) _____ (MI) _____DOB_____ MALE ____FEMALE ____

ADDRESS *(PLEASE NO P.O. BOX)* _____

HOME PHONE _____ CELL _____ WORK _____ S.S. #_____

EMPLOYER NAME _____ OCCUPATION _____

EMPLOYER ADDRESS _____

SECONDARY INSURANCE ☐ CHECK THIS BOX IF INFORMATION IS THE SAME AS ABOVE

INSURANCE NAME _____ RELATIONSHIP TO SUBSCRIBER: SELF ___ SPOUSE ___ CHILD ___

SUBSCRIBER (LAST) _____ (FIRST) _____ (MI) _____DOB_____ MALE ____FEMALE ____

ADDRESS *(PLEASE NO P.O. BOX)* _____

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** 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* _____