LUX SMILES

Dental Registration

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Date_____

PATIENT INFORMATION

Name_____ **Soc. Sec. #**_____
Last Name First Name Middle

Address_____ **Apt #**_____

City_____ **State**_____ **Zip**_____

Home Phone (_____)_____ **Mobile Phone** (_____)_____ **Other** (_____)_____

Sex ☐ Male ☐ Female **Age**_____ **Birth Date**_____ **Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By_____ **Occupation**_____

Business Address_____ **Business Phone** (_____)_____

In case of emergency who should be notified?_____

Whom may we thank for referring you?_____

PRIMARY INSURANCE

Person Responsible for Account_____
Last Name First Name Middle

Relation to Patient_____ **Birth Date**_____ **Soc. Sec. #**_____

Address (if different from Patient's)_____ **Apt #**_____

City_____ **State**_____ **Zip**_____ **Phone** (_____)_____

Person Responsible Employed By_____ **Occupation**_____

Business Address_____ **Business Phone** (_____)_____

Insurance Company_____

Contract #_____ **Group #**_____ **Subscriber #**_____

Names of other dependents under this plan_____

ADDITIONAL INSURANCE

Is the patient covered by other insurance? ☐ Yes ☐ No

Subscriber Name_____
Last Name First Name Middle

Relation to Patient_____ **Birth Date**_____ **Soc. Sec. #**_____

Address (if different from Patient's)_____ **Apt #**_____

City_____ **State**_____ **Zip**_____ **Phone** (_____)_____

Subscriber Employed By_____ **Occupation**_____

Business Address_____ **Business Phone** (_____)_____

Insurance Company_____

Contract #_____ **Group #**_____ **Subscriber #**_____

Names of other dependents under this plan_____

ACKNOWLEDGEMENT & AUTHORITY

I consent to the treatment as necessary or desirable to the care of the patient first named above, including, but not limited to whatever drugs, medicine, performance of operations and conduct of the laboratory, X-ray, or other studies that may be used by the attending doctor, or his qualified designate. I also acknowledge full responsibility for the payment of such services, whether I have insurance coverage or not, and I agree to pay for them, in full, at the time of service, unless other arrangements are made. I understand that accounts more than 60 days overdue are subject to a service charge of 1 1/2% per month (18% annual percentage rate), and I am responsible for attorney's fees, collection fees, or court costs incurred in the collection of a delinquent account. I understand that where appropriate, a credit may be made through a credit bureau.

_____ _____ _____ _____
Responsible Party, Patient, Parent or Agent Signature | Responsible Party Name (Print) | Relationship | Date

INSURANCE RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assigned directly to
Name of Insurance Company(ies)
Jai H. Shin, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. A copy of this authorization shall be as valid as the original. I also authorize Jai H. Shin, D.D.S. to release to the insurance company any information acquired in the course of examination or treatment relating to my insurance claim. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and the use of this signature on all insurance submissions.

_____ _____ _____ _____
Responsible Party, Patient, Parent or Agent Signature | Responsible Party Name (Print) | Relationship | Date