PATIENT REGISTRATION

Office of Dr. Steven Seibert, D.M.D., M.S. & Dr. Yoolim Kim, D.M.D., M.S.D.

Please Print Today's Date _____

Patient Name _____

Home Phone # _____ - _____ Work Phone # _____-_____ Cell # _____-_____

Home Address _____
Must be completed if mailing address is a Post Office Box

City _____ State _____ Zip _____

Mailing/Billing Address _____ E-Mail _____
If different than above home address

City _____ State _____ Zip _____

_____ Male _____ Mr. _____Ms. ____ Dr. ____ Sr. ____ Married ____ Head of House
_____ Female _____ Mrs. _____ Miss ____ Rev. ____ Fr. ____ Single ____ Divorced

Social Security # _____ - _____ - _____ Birth Date _____ - _____ - _____

Drivers License #_____ Issuing State _____
(Necessary For Check Writing and/or Setting up Financial arrangement)

Employer/Business Name _____

Address _____ City _____ State _____ Zip_____

Referred by Dr._____ General Dentist *(if different than referring dentist)* _____

Medical Dr. _____

Is patient a full time student? _____ Yes _____ No School Name _____ City _____ State_____

How did you hear about our office? ____ Referring Dentist ____ Existing Patient ____ Yellow Pages ____ Church Directory
____ Newspaper ____ Other (explain) _____

Complete if Patient is a Minor Please Print

Parent/Guardian Name _____

Relationship to patient ____ Mother ___ Father ___ Legal Guardian ____ Other *explain* _____

Home Address _____

City _____ State _____ Zip _____

Social Security # _____ - _____ - _____ Birth Date _____ - _____ - _____

Drivers License #_____ Issuing State _____
Necessary For Check Writing and/or Setting up Financial arrangement)

Employer/Business Name _____ Business Phone Number _____-_____-_____

Address _____

City _____ State _____ Zip _____

Continued on reverse side

Do You (the patient) have DENTAL INSURANCE COVERAGE? ____ YES ____ Primary ____ 2ndary / _____ NO

If yes the following must be completed in full.

Primary Dental Insurance Company Name_____

Insurance Mailing Address _____ City _____ State _____

Zip _____ Insurance Phone # ____- _____-_____ Group ID # _____ Plan Name _____

Employee/Owner of Policy Name _____ Birth Date ___-___-___ Social Security # ____ ____ ____

Relationship to patient ____Self ____Spouse ____Mother ____Father ____Step Mother ____ Step Father

Employer/Company/Work Name _____
Work Address _____ City _____
State _____ Zip _____ - _____ Home Phone # _____- _____ Work Phone # _____- _____
Employee ID # *if applicable* _____ Patient ID # *if applicable* _____

Secondary Dental Insurance Company Name _____

Insurance Mailing Address _____ City _____ State _____

Zip _____ Insurance Phone # ____- _____-_____ Group ID # _____ Plan Name_____

Employee/Owner of Policy Name _____Birth Date ___-___-___ Social Security # ____ ____ ____

Relationship to patient ____Self ____Spouse ____Mother ____Father ____Step Mother ____ Step Father

Employee/Company/Work Name _____
Work Address _____ City _____
State _____ Zip _____ - _____ Home Phone # _____-_____ Work Phone # _____-_____
Employee ID # *if applicable* _____ Patient ID # *if applicable* _____

The patient must supply a new complete, signed and dated form if any changes occur.

Signature of patient/insured person to authorize payment of Dental Benefits to Dr. Steven W. Seibert (if balance exists). X_____

RELEASE OF INFORMATION

I authorize the release of any dental information necessary to process any and all claims.

I understand and agree that regardless of insurance status I am ultimately responsible and agree to pay for the total outstanding balance.

The undersigned hereby understands and agrees that the undersigned is responsible for payment of any and all professional services rendered to the undersigned, and/or the undersigned's spouse, children, or any ward to which the undersigned is a guardian, and are obligated for such services whether or not the undersigned is entitled to reimbursement from a third party guarantor or obligor for payment of such services. The undersigned agrees that the undersigned shall be liable, in addition to all professional services rendered to the undersigned, any and all collection costs, attorney's fees and court costs and expenses incurred in collection for such bill. The undersigned shall also be liable for interest charged on any unpaid balance in the amount of 1.5% monthly (18% ANNUALLY) on all unpaid balances.

A $25.00 FEE OR THE MOST ALLOWABLE BY LAW WILL BE CHARGED FOR ANY CHECK RETURNED FOR ANY REASON. In addition to any fee charged for any check returned for insufficient funds, the undersigned shall also be liable for, in addition to the amount owing upon such check, triple the amount so owing, but in no case less than $100 and no more than $1500, plus attorney's fees and court costs pursuant to 720 ILCS 5/17-1(a).

I understand and agree that services rendered, which are not paid at the time of service, will be set up on an agreed payment plan and/or legal contract.

I understand any and all services rendered at the Charleston location are for the patient's convenience and all billing, financials, etc. are rendered at the main Champaign office. The undersigned agree any legal or equitable action by Dr. Seibert seeking collection of unpaid balance, shall be venued in Champaign County.

Patient Signature X_____ **Date X**_____

Complete if Patient is a Minor:

Parent/Guardian Name *please print* _____ **Parent/Guardian Signature** _____ **Date** _____