Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

James J Hur DDS 1402 36th Street SW Wyoming MI 49509 ph: 616-534-3362 email: dianevd@tds.net

PATIENT INFORMATION

Name _____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other: _____
First MI Last

Address _____ Occupation: _____ [ ] Male [ ] Female

City _____ State _____ Zip _____ Hm# (___)_____

Employer _____ Wk# (___)_____Ext _____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell # (____)_____

DOB: ____/_____/_____SSN# _____ E-mail _____@_____

Spouse's Name _____
First MI Last (if different)

Spouse occupation _____ Work phone _____Ext _____

Is patient a full time student? [ ] No [ ] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Hm# (___)_____

Wk# (___)_____

DOB: ____/_____/_____

SSN# _____

Relationship: _____

YOUR PREFERENCES

Do you prefer appointment reminders by:
[ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at:
[ ] Home [ ] Work [ ] Cell

Whom may we thank for referring you?

_____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to patient: _____

DOB: _____/_____/_____ Subscriber's SSN# _____

Insurance Company _____ Policy # _____ Group #_____

SUPPLEMENTAL INSURANCE (DENTAL):

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name _____ Relationship to patient: _____

Address _____ City _____ State _____ Zip _____

DOB: ____/____/_____SSN# _____ Employer: _____

Insurance Company _____ Group # _____ Eff. Date: ___/___/____

I certify that I (or my dependent) have the insurance coverage listed above and assign directly to Dr James J Hur all insurance benefits, if any, for services rendered. If my insurance company fails to pay or I have no insurance, I am financially responsible for all charges incurred. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signed:_____Date:_____

_

CONFIDENTIAL