

David J. Lim, M.D., P.A.
Registration Form

Date _____

Name _____ Soc. Sec. # _____

First Name Middle Last Name

Address _____

City _____ State _____ Zip _____ County _____

Day Phone _____ Cell or Evening Phone _____

Sex: Male _____ Female _____ Age _____ Birthdate _____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____

Patient Employer _____ Business Phone _____

Occupation _____

Emergency Contact _____ Phone _____

Primary Insurance

Person Responsible for Account _____

First Name Last Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____

City _____ State _____ Zip _____ Phone _____

Spouse (or responsible party) Employed By _____

Business Address _____ Business Phone _____

Insurance Company _____ Subscriber # _____

Group # _____

Do you have Advanced Directives? Yes _____ No _____

Assignment and Release

Assignment of benefits: I authorize payment of medical benefits to myself or the named provider for professional services rendered.

Signed _____

Release of information: I authorize the release of any medical information necessary to process this claim.

Signed _____