LET'S GET ACQUAINTED

In order to serve you better, it is requested that you fill in the following information:

PATIENT INFORMATION:

Name _____ Nickname _____
Last First Middle

Social Security No. _____ Birthdate ___/___/___ Age _____

Driver's License No. _____ Home Phone (___) _____

E-mail _____ Fax # (___) _____ Cell # (___) _____

Pager # (___) _____

Home Address _____ City _____ Zip _____

Marital Status ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Your Occupation _____ Employer _____

Business Address _____ City _____ Zip _____

Work Phone (___) _____ How long have you worked there? _____

Any hobbies? _____

Whom may we thank for referring you to our office? _____

IN AN EMERGENCY WE MAY CONTACT:

Nearest friend or relative _____ Phone (___) _____

Address _____ City _____ Zip _____

PERSON RESPONSIBLE FOR PAYMENT IF NOT THE SAME AS ABOVE.

Name _____ Relationship to patient _____

☐ My address and phone number is the same as above. (If different, please complete below.)

Address _____ City _____ Zip _____

Home phone (___) _____

Employer _____ Business Address _____

City _____ Zip _____ Work Phone (___) _____

INSURANCE INFORMATION:

PRIMARY CARRIER:

Name of insured _____ Social Security No. _____

Birth date ___/___/___ Name of Insurance Company _____

Group No. _____ Union Local No. _____ Group Plan Name _____

Address _____ City _____ Zip _____

If you have a second insurance carrier, please supply the following information:

Name of insured _____ Social Security No. _____

Birth date ___/___/___ Name of Insurance Company _____

Group No. _____ Union Local No. _____ Group Plan Name _____

Address _____ City _____ Zip _____

Raymond W. Lim, DDS

02/01

MEDICAL HISTORY

Please check any past or present condition that you had in the past or presently have:

( ) Rheumatic Fever
( ) Heart Murmur
( ) Any Heart Problems
( ) Artificial Heart Valve
( ) Heart Pacemaker
( ) Anemia
( ) Blood Disease
( ) Excessive Bleeding
( ) High Blood Pressure
( ) Arthritis
( ) Thyroid Problems
( ) Diabetes

( ) Stroke
( ) Epilepsy
( ) Kidney Disease
( ) Liver Disease
( ) Tumor History
( ) Venereal Disease
( ) Allergies
( ) Asthma
( ) Glaucoma
( ) Psychiatric Treatment
( ) Sinus Problems

( ) Faintness
( ) HIV Positive
( ) A.I.D.S
( ) Immuodeficiency Disease
( ) Cancer
( ) X-ray or Radiation Treatment
( ) Artificial Joints (Hips, knee, etc.)
( ) Diet Pills
( ) Fen Phen

Hepatitis
( ) A (Infectious)
( ) B (Serum)
( ) Tuberculosis(TB)

Allergic To:
( ) Penicillin
( ) Aspirin
( ) Codeine
( ) Latex or rubber
( ) Dental Anesthetic
( ) Other Medication

( ) I have no medical problems listed above.

Any other medical condition not mentioned above: _____

What medication are you presently taking? _____

Physician's name or clinic _____ Specialty _____

Address _____ City _____ Zip _____

Phone No. ( ) _____

Women only: Are you pregnant? No ( ) Yes ( ) How many Months? _____

Are you taking birth control pill? No ( ) Yes ( )

Remarks _____

DENTAL HISTORY (PLEASE COMPLETE FULLY)

Name of former dentist or clinic _____ Phone number ( ) _____

Address _____ City _____ Zip _____

Date of last visit _____ Purpose of today's visit _____

What are your goals for your teeth? _____

Any previous condition we should be aware of? _____

Remarks _____

_____

CONSENT

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed necessary by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, use of anesthetic agents, medication and therapy, that may be indicated in connection with _____ (Name of Patient).

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine and is due and payable at the time services are rendered (even if I have dental insurance) unless financial arrangements have been made with Doctor's office. I further understand that 1-1/2% finance charge (18% annual rate) will be added to any balance over 30 days. I also agree that in the event of default in the payment of any amount due,and if this account is placed in the hands of an agency for collection or legal action, to pay an additional charge equal to the cost of collection including bookkeeping, agency, and reasonable attorney fees and court costs incurred as permitted by laws governing these transactions.

I hereby authorize and direct my Insurance company to pay directly to Doctor any benefits that may accrue to me under my insurance plan.

_____ _____
Patient's Signature (Parent or Guardian if under 18) Date

_____ _____
Witness Date

Raymond W. Lim, DDS

5/99

Raymond W. Lim, D.D.S.
Family Dentistry

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www.MySanJoseWillowGlenDentist.com
Email: drraymondlim@sonic.net

Dear New Patient:

Welcome to Dr. Lim's family dental practice! I would like to take this moment to thank you for trusting our office in the total care of your mouth. We are here to make sure that you receive comprehensive high quality and gentle dental treatment in a friendly environment.

This is our mission to you:

The reason this office exists is because of YOU, the patient. Because without you supporting us, there is no reason why we should be here to meet all your dental needs. Dr. Lim and the staff promise to provide you and your family and your thoughtful referrals with the best skilled dental care in a friendly, thoughtful, and caring environment for the next few decades. We promise that our skills will always be kept current through continued education and proper training to provide you with the solutions required to solve your dental needs in maintaining a healthy mouth and smile.

I would also like to familiarize you and your family in the services and policies of this office.

Our office hours presently are Monday from 11 a.m. to 6 p.m., Tuesdays and Thursdays from 10 a.m. to 7 p.m., Wednesday from 9 a.m. to 6 p.m., and Friday from 9 a.m. to 2 p.m. and Saturdays by appointment to accommodate your schedule.

We do ask you to give our office at least 24 hours notice for any appointment cancellation. This is to insure that we can schedule all of our valuable patients properly for their dental work. However, if we do not receive a 24 hour notice for cancellation, the office may charge a $20.00 cancellation fee, which the insurance companies will not pay. If you must cancel an early evening (from 4:30 p.m. to 7 p.m.) appointment without the proper notice, please be aware that a $30.00 cancellation fee will automatically be charged to you.

All new patients (even if you have insurance) are required to pay in full for the initial visit unless prior arrangements have been made with the staff. With subsequent visits, charges are also payable at the time of service. For those patients with dental insurance, your patient portion is payable at the time of service. If you require extensive work, we will be glad to arrange financing or a payment plan for you.

Again, welcome to our practice. We wish that your visits in this office are pleasant. We look forward to a happy and lasting relationship.

For a happier smile,

Dr. Raymond W. Lim and Staff

I have read and understand the policies of Dr. Lim's office.

_____ _____

Signature Date