Advanced Rheumatology & Arthritis Center
Jim C. Kim, MD
2203 17th Street
Bakersfield, CA 93301
(661) 716-0333 Fax (661) 716-1288

REGISTRATION FORM

Date: _____ Family Physician: _____ Referring Physician: _____
(Please Print Full Name) (Please Print Full Name)

Patient Information

Name: _____ Social Security #: _____ - _____ - _____
First MI Last

Address: _____ Date of Birth: _____ / _____ / _____

City: _____ State: _____ Zip: _____ Preferred Phone: (_____) _____

Age: _____ Sex: ☐M ☐F ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Race_____ Ethnicity (Circle One): Hispanic/Latino **OR** Not Hispanic/Latino

Emergency Contact:_____ Relationship:_____ Phone: (____)_____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: (_____) _____

Primary Insurance

Insurance Company: _____ Name of Primary Insured: _____

Social Security of Primary Insured: _____ Date of Birth of Primary Insured: _____

Policy / ID #: _____ Group #: _____

Additional Insurance

Insurance Company: _____ Name of Primary Insured: _____

Social Security of Primary Insured: _____ Date of Birth of Primary Insured: _____

Policy / ID #: _____ Group #: _____

Assignment and Release

I certify that I have insurance coverage with above Insurance Company(ies) and assign directly to Jim C. Kim, M.D., Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, unless specified by insurance contract.
Jim C. Kim, M.D., Inc may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

X_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient