KASEY K. LI, DDS, MD, FACS

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PATIENT INFORMATION

Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Patient Name: _____ Home Phone #: _____
Last First Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____ Work Phone #: _____ Cell Phone #: _____

Employer/Occupation: _____ Social Security #: _____

Person to notify in an emergency: _____ Relationship: _____

Phone #: _____ Work Phone #: _____ Cell Phone #: _____

REFERRING PHYSICIAN INFORMATION

Referring Dentist/Physician: _____ Phone #: _____

Family Physician: _____ Phone #: _____

Family Dentist: _____ Phone #: _____

INSURANCE INFORMATION

Person responsible for payment: _____ Relationship: _____

Medical/Dental Insurance Company: _____

Policy Holder: _____ Identification #: _____ Group #: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Secondary Medical/Dental Insurance: _____

Policy Holder: _____ Identification #: _____ Group #: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

IMPORTANT ADVISORY NOTICE

PLEASE NOTE: Dr. Kasey Li accepts all PPO insurance plans, but he is NOT a participating provider and is not in any insurance network plans. If you have a PPO plan, any treatment rendered by Dr. Li is considered an out-of-network service. Patients with or without insurance coverage are financially responsible for all fees. All services provided will be billed to your insurance company. However, if the insurance claim is not paid within 90 days of the date of services, you are responsible for the outstanding amount.

Signature: _____ Date: _____