

# KASEY K. LI, DDS, MD, FACS

University Circle • 1900 University Avenue, Suite 105 • East Palo, CA 94303  
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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: \_\_\_\_\_