Jeffrey N. Kenney, D.D.S.

Patient Registration Form

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Sex: Male ☐ Female ☐ Social Security #: _____ Date of Birth: _____ Age _____

Occupation: _____ If Student, School: _____

If Employed, Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

My Dentist is: _____ I was referred to this practice by: _____

RESPONSIBLE PARTY (If different than patient):

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____ Relationship to Patient: Spouse ☐ Parent ☐ Other ☐ _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Occupation:) _____

Employer: _____ Address: _____

PRIMARY INSURANCE INFORMATION: Medical

Insurance Company Name: _____ Telephone: _____

Claims Address: _____

Type of Insurance: Medical _____ Dental _____ Both Medical and Dental _____ (PPO ☐ POS ☐ HMO ☐ DHMO ☐)

Policy ID#: _____ Group # _____ Plan #: _____

Policyholders's Name _____ SS#: _____

Date of Birth: _____ Relationship to Patient: Spouse ☐ Parent ☐ Other ☐ _____

Employer: _____ Address: _____

SECONDARY INSURANCE INFORMATION: Dental

Insurance Company Name: _____ Telephone: _____

Claims Address: _____

Type of Insurance: Medical _____ Dental _____ Both Medical and Dental _____ (PPO ☐ POS ☐ HMO ☐ DHMO ☐)

Policy ID#: _____ Group # _____ Plan #: _____

Policyholders's Name _____ SS#: _____

Date of Birth: _____ Relationship to Patient: Spouse ☐ Parent ☐ Other ☐ _____

Employer: _____ Address: _____

An estimate of the charge for any procedure or surgery you may require will be given to you. I understand I am financially responsible for payment of all services at the time they are rendered, unless other payment arrangements have been established. Please remember that insurance is considered a method of reimbursing the patient for fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I hereby authorize to patient by the above physician and /or any affiliated medical staff member(s). I further authorize release of any and all medical and/or charge information as is necessary for third party reimburse from my insurance carrier. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all charges incurred as well as attorney's fees of 33 1/3% and any other costs of collection should such action become necessary.

Signature of Patient/Responsible Party: _____ Relationship to Patient _____ Date _____