# Jeffrey N. Kenney, D.D.S.

Patient Registration Form

**PATIENT INFORMATION:**

Last Name: ____________________ First Name: ____________________ Middle Initial: ______

Address: ____________________ Apt#: _______ City: ________________ State: _______ Zip Code: _________

Cell Phone: (      ) ________________ Home Phone: (      ) ________________ Work Phone: (      ) ________________

Sex: Male ☐ Female ☐ Other ☐ Social Security #: ________________ Date of Birth: ____________ Age ________

Occupation: ____________________ If Student, School: ____________________

If Employed, Employer: ________________________________________

**PATIENT EMAIL ADDRESS** (parent or legal guardian email for minors) ____________________

Emergency Contact: ____________________ Phone: ________________ Relationship: ____________

**NAME OF DENTIST**: ________________________________________

**RESPONSIBLE PARTY (parent or legal guardian for minors accompanying patient):**

Last Name: ____________________ First Name: ____________________ Middle Initial: _______

Address: ____________________ Apt#: _______ City: ________________ State: _______ Zip Code: _________

Social Security #: ______________ Date of Birth: ____________ Relationship to Patient: Spouse ☐ Parent ☐ Other ☐___________

Cell Phone: (      ) ________________ Home Phone: (      ) ________________

Email: ________________________________________

**INSURANCE INFORMATION: <u>MEDICAL</u> (Policy Holder Information)**

Insurance Company Name: ____________________ Telephone: ________________

Claims Address: ________________________________________

Policy ID#: ________________ Group # ________________ Plan #: ________________

Policyholder's Name (If different from patient )____________________ SS#: ________________

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

Employer: ________________________________________

**INSURANCE INFORMATION: <u>DENTAL</u> (Policy Holder Information)**

Insurance Company Name: ____________________ Telephone: ________________

Claims Address: ________________________________________

Policy ID#: ________________ Group # ________________ Plan #: ________________

Policyholder's Name (If different from patient )____________________ SS#: ________________

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

Employer: ________________________________________

AN ESTIMATE of the charge for any procedure or surgery I may require will be provided. I understand I am financially responsible for payment of all services at the time they are rendered. I understand 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. I acknowledge it is the responsibility of the patient/guarantor to pay any deductible amount, co-insurance or any other balance not paid for by the insurance company.

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I hereby authorize treatment by the above doctor 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 __________