Welcome

Leigh W. Kent, D.D.S., Ph.D.

Practice Limited to Dental Implants and Periodontics

PATIENT REGISTRATION

Date: _____Home Phone:_____

Patient: _____
Last Name First Name Middle Initial

Name you wish to be called: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip:_____

Email address:_____Permission to use your email_____

Birthday: _____ Social Security # : _____

Business Phone: _____ Alternate phone:_____

Responsible party:_____ Relation to patient: _____

Primary Insurance: _____ Birthday:_____
(Policy Holder's Name)

Insured's SS # _____ Insured's employer: _____

Employer's Address: _____ Phone: _____

Dental Insurance Company: _____

Policy Number: _____Group #: _____

Secondary Insurance: _____

Preferred Pharmacy: _____Pharmacy Phone: _____
(We will call prescriptions to the above pharmacy.)

Who may we thank for referring you? _____

The patient/responsible party agrees to be fully financially responsible to, and agrees to pay, Leigh W. Kent, D.D.S., Ph.D., PC for all charges submitted for services rendered to patient to the extent not expressly prohibited by applicable law or our contract with a third party payor. The patient/responsible party agrees to pay even though there may be insurance or other third party coverage, or even though the charges may exceed the amount reimbursed by insurance. Overdue accounts may be placed with an attorney for collection. In the event an account is turned over to an attorney, the patient/responsible party agrees to pay any attorney's fee, court cost, and any other reasonable cost of collection. We gladly accept cash, check, Visa, or Mastercard.

Signature :_____