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: ____

Address: ____

City: ______________________ **State:** _________ **Zip:** _____________

Email address: ________________________ **Permission to use your email** _____

Sex: M F **Birthday:** _____________ **Social Security # :** _______________

Employed By: ____

Business Address: ____

Business Phone: __________________ **Alternate phone:** _________________

Responsible party: ______________ **Relation to patient:** __________________

Insured's name: _____________________________ **Birthday:** _____________

Insured's SS # ____________________ **Insured's employer:** _______________

Employer's Address: __________________________ **Phone:** _____________

Dental Insurance Company: _____________________ **Group #:** ___________

Preferred Pharmacy: ___________________ **Pharmacy Phone:** ___________

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 : ____