

## PATIENT REGISTRATION & INSURANCE

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Email \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Please circle: Patient's Marital Status: S M W D Patient's Sex: F M  
 Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer's Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ May we call you at your work number? YES NO  
 Spouse's Name (Or parent's name if patient is a minor) \_\_\_\_\_  
 Spouse's Address ("Same" acceptable) \_\_\_\_\_  
 Spouse's Employer & Address \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_ May we call them at this work number? YES NO  
 Your Social Security # \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_  
 Physician Name \_\_\_\_\_ Last Visit \_\_\_\_\_  
 Whom should we contact in case of emergency? \_\_\_\_\_ Phone \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Hobbies or interests? \_\_\_\_\_

### COMPLETE THIS SECTION IF YOU HAVE DENTAL INSURANCE(S)

Primary Insurance	Secondary Insurance
Insured's Name _____	Insured's Name _____
Group # _____ ID# _____	Group # _____ ID# _____
Employer _____	Employer _____
Insurance Carrier _____	Insurance Carrier _____
Insured's Birthdate _____	Insured's Birthdate _____

**READ CAREFULLY AND UNDERSTAND WHAT YOUR SIGNATURE MEANS.** Your signature below serves many purposes. It indicates you have reviewed your medical history on the other side of this paper and updated and corrected it as appropriate. It also indicates you have reviewed your personal registration information above (especially your phone numbers) to ensure that it is correct. Also, your signature below shall constitute your "Signature on File" with your insurance company (if applicable) for assignment of your insurance benefits to Dr. Kevin Bone, D.D.S. and the release of information to all your insurance carriers. And finally, the undersigned agrees, whether or not he/she is insured, that in consideration of the services rendered to the patient, he or she individually obligates themselves to pay this account upon receipt of the initial bill for the above mentioned services and/or acknowledges that he or she is primarily responsible for payment of the account notwithstanding the existence of other sources of payment, unless previous financial arrangements have been made with the Financial Coordinator. Your signature also is a promise that you will keep all scheduled appointments.

Signature _____	Date _____	Signature _____	Date _____
Signature _____	Date _____	Signature _____	Date _____
Signature _____	Date _____	Signature _____	Date _____
Signature _____	Date _____	Signature _____	Date _____