M. Todd Bonin, D.D.S.

PATIENT INFORMATION

Name_____ ☐Married ☐Single ☐Other ☐M ☐ F
First M. Last

"Preferred"_____ Age_____ DOB____/____/_____

Address_____
Street Apt# City State Zip

Contact Info: Home Telephone(s)_____

Cell Phone_____ Work Phone_____

Email Dental Newsletter: would you like to receive it quarterly? ☐ Yes ☐ No

Email: _____ Pager_____

Employed By_____ SSN_____

How Did You Hear About Our Office? _____

Who Can We Thank For Referring You?_____

Emergency Contacts: (1) _____
Name Phone(s)

(2) _____
Name Phone(s)

RESPONSIBLE PARTY INFORMATION ☐ Self ☐ Parent ☐ Spouse ☐ Other

Name_____ DOB____/____/_____
First M. Last

Address_____
Street Apt# City State Zip

Contact Info: Home Telephone(s)_____

Cell Telephone_____ Work Telephone_____

Email: _____ Pager_____

Employed By_____ SSN_____

Please give your insurance card any other information pertaining to your Insurance to the front desk so copies can be made. I authorize and request my insurance company to pay directly to Dr. Bonin. I understand that I am required to pay all co-pays and deductibles at the time services are rendered. I also understand that insurance may not pay for certain treatment(s) or might downgrade certain treatments to lesser amounts making me responsible for higher co-pay. Insurance estimates done by office are just "estimates" and not a guarantee of payment. If my account becomes delinquent, it will be subject to professional collection and I agree to be responsible for all costs, including collection fees, court costs, and attorney's fees.

_____ _____
Patient / Guardian/ Parent Signature **Date**