WELCOME

Dr. Henry A. Knowles, Jr. ~ 4318 Kelson Avenue ~ Marianna, FL 32446 ~ (850) 526-3939

NAME: ______________________________ DATE: ______________
ADDRESS: ______________________CITY: ____________ STATE: ____ ZIP: _____
AGE: _______ DOB: __________________ SS#: ____________________
HOME PHONE: __________________CELL PHONE: ________________ MALE FEMALE
SINGLE _____ MARRIED _____ WIDOWED _____ DIVORCED _____
EMPLOYER: ___________________________ EMPLOYER PHONE #: ______________

SPOUSES NAME: ____________________ SS#: ____________________
SPOUSE'S DOB: ____________________ CELL PHONE #: ________________
SPOUSE'S EMPLOYMENT: _________________EMPLOYER PHONE #: ______________

PLEASE CONTACT ME BY: VOICE CALL TEXT MESSAGE EMAIL
TO CONFIRM MY UPCOMING DENTAL APPOINTMENTS (circle all that apply)
EMAIL: ____

IN CASE OF EMERGENCY, WE SHOULD CONTACT: ______________________________
PHONE #: ______________________ RELATIONSHIP TO PATIENT: ______________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? ____________________

Will Dr. Knowles' office be filing dental insurance for you? YES NO

INSURANCE COMPANY: ____
POLICY HOLDER: ____________________INSURANCE PHONE #: ________________

Should it become necessary to place my account with a collection agency, I agree to pay all fees associated with the collection of my debt.

PATIENT SIGNATURE: ______________________________ DATE: ____________

AGREEMENT AND RELEASE

I, the undersigned, certify that I have dental insurance coverage with ________________ and assign to Dr. Henry A. Knowles, Jr., D.M.D., P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

INSURED PARTY SIGNATURE: ____
RELATIONSHIP TO PATIENT: ________________________ DATE: ________________