WELCOME

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

CHILD'S NAME: _____DATE: _____
ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____
AGE: _____ DOB: _____SS#: _____
HOME PHONE: _____CELL PHONE: _____ MALE FEMALE

FATHER'S NAME: _____ SS#: _____
FATHER'S EMPLOYMENT: _____ WORK PHONE: _____
HOME PHONE: _____CELL PHONE: _____

MOTHER'S NAME: _____ SS#: _____
MOTHER'S EMPLOYMENT: _____ WORK PHONE: _____
HOME PHONE: _____CELL PHONE: _____

TO CONFIRM MY CHILD'S DENTAL APPOINTMENTS, PLEASE CONTACT ME BY (CIRCLE ALL):
PHONE CALL TEXT MESSAGE 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 your child? 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.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

AGREEMENT AND RELEASE

I, the undersigned, certify that I (for my dependent) 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: _____