Carl L. Knox, D.D.S

Family Dentistry

14818 Pacific Avenue • Tacoma, WA 98444 • 531-0638 • www.carlknoxdds.com

Patient Registration - Adult -

Thank you for choosing us to provide your dental care. We hope to return your expression of confidence in us by providing the highest quality care we can deliver and still keep the expense to you within reason. Our **top** priority is improving your health and we refuse to cut corners in striving for that goal. If our work is of highest quality and if we can spend the time with you to teach you how to maintain it, your initial expenditures toward improving your health will become long - term investments. But our goals can be reached only if they also meet **your** goals. Please feel free to tell us your concerns and desires - only then can we know we are doing things the way you want them to be done. You have the right to understand any proposed treatment before accepting it.

1) Patient's Name Mr. Mrs. Miss _____ Date of Birth _____ Today's Date _____
First Middle Last

2) By which name would you like to be addressed? _____ Social Security # _____ Occupation _____

3) Home Address _____ Home Phone _____
Street City State Zip Code

4) Employer Name _____ Employer Address _____
Street City State Zip Code

5) Work Phone _____ Length of time worked for employer _____

6) Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Separated _____ Spouse Name _____

7) Spouse Employer Name _____ Spouse Employer Phone _____

8) Spouse Employer Address _____ Length of Employment _____
Street City State Zip Code

9) Person financially responsible (if other than patient) _____
Name Street City State Zip Code

10) Person to notify in case of emergency _____ Home Phone _____ Work Phone _____ Relationship _____

11) Whom may we thank for referring you? _____

Insurance Information

Insurance 1st Coverage

Subscriber Name _____

Soc. Sec. # _____ Date of Birth _____

Employer _____ #Yrs. _____

Name of Insurance Co. _____

Name of Union _____ Local # _____

Program or Policy # _____

Patient Relationship to Subscriber _____

"I authorize release of records for insurance purposes."

Signed _____ Date _____

"I authorize payment of insurance benefits to dentist."

Signed _____ Date _____

Insurance 2nd Coverage

Subscriber Name _____

Soc. Sec. # _____ Date of Birth _____

Employer _____ #Yrs. _____

Name of Insurance Co. _____

Name of Union _____ Local # _____

Program or Policy # _____

Patient Relationship to Subscriber _____

"I authorize release of records for insurance purposes."

Signed _____ Date _____

"I authorize payment of insurance benefits to dentist."

Signed _____ Date _____