Carl L. Knox, D.D.S

Family Dentistry

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

Patient Registration - Dependent/Child

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 for your child before accepting it.

Patient's Name_____ Date of Birth_____ Today's Date_____
First Middle Last

How do you wish to be addressed?_____ Sex_____ Social Security #_____ Occupation_____

Home address _____ Home Phone_____
Street City State Zip Code

Person financially responsible _____

PARENT/GUARDIAN INFORMATION

Parent #1

Name _____

Home address
Street_____

City_____ State_____ Zip_____

Employer
Name _____
Address
Street_____

City_____ State_____ Zip_____

Phone: Home_____ Work_____

Occupation _____

Date of Birth _____

INSURANCE 1ST COVERAGE

Name of Insurance Co. _____

Length of time worked for employer _____

Name of Union _____ Local #_____

Program or Policy #_____ Soc. Sec. # _____

Patient relationship to subscriber _____

"I authorize release of records for insurance purposes."

Signed _____ Date_____

"I authorize payment of insurance benefits to dentist."

Signed _____ Date_____

Parent #2

Name _____

Home address
Street_____

City_____ State_____ Zip_____

Employer
Name _____
Address
Street_____

City_____ State_____ Zip_____

Phone: Home_____ Work_____

Occupation _____

Date of Birth _____

INSURANCE 2ND COVERAGE

Name of Insurance Co. _____

Length of time worked for employer _____

Name of Union _____ Local #_____

Program or Policy #_____ Soc. Sec. # _____

Patient relationship to subscriber _____

"I authorize release of records for insurance purposes."

Signed _____ Date_____

"I authorize payment of insurance benefits to dentist."

Signed _____ Date_____

Person to notify in case of emergency_____ Home Phone_____ Work Phone_____ Relationship_____

Whom may we thank for referring you? _____

I, _____, being the parent, guardian, or other person entitled to legal custody of _____, a minor child, do hereby authorize and consent to any x-ray, examination, anesthetic, or dental treatment to be rendered to said minor child under the general or direct supervision of Carl L. Knox, DDS, as the dentist may deem necessary.

This authorization will remain in effect until _____(date).

Signed _____ Date_____