Gary Knerr, DDS

General Dentistry

PATIENT INFORMATION

Date _____

Patient's Name _____

Date of Birth _____

Social Security # _____

If child, parent's name _____ Soc. Sec _____

Residence address _____

City _____ State _____ Zip _____

E-Mail Address _____

Home Telephone # _____ Work Phone # _____ Cell Phone # _____

Driver's Lic # _____ Single___ Married___ Widowed___ Divorced___

Employer _____ Position _____

Work address _____

Dental Ins. Co _____ Address _____ Group # _____

Purpose of your Visit Today _____

REFERRED BY _____

SPOUSE INFORMATION

Name _____

Date of Birth _____

Social Sec # _____

Home phone # _____ Work Phone # _____ Cell Phone # _____

Employer _____ Address _____ Position _____

Dental Ins CO _____ Address _____ Group # _____

Is another member of your family a patient in our practice? _____

1. I understand there is a $55 charge without 24 hr notice of cancellation (Initial)_____
2. I consent to exam , x-rays, local anesthetic and necessary treatment. (Initial)_____
3. I hereby authorize assignment of my insurance rights and benefits directly to the provider for for necessary services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. (Initial) _____

Method of Payment: Check ____ Cash ____ Visa ____

(*Sign Here*) _____