PATIENT INFO SHEET (Adult)

Patient's Full Name:_____

Home Address:_____

City:_____State:____Zip: _____ Date of Birth: _____

Cell #: _____Email Address: _____

Patient's Employer: _____ Patient's Dentist_____

Who referred you to Dr. Knight's office: _____

Who will be financially responsible for this account:_____

Relationship of responsible party to patient:_____

Name/Phone # of **Primary** Dental Insurance: _____/_____

Responsible Party's Social Security # and Birthdate:_____/_____

Insurance Claims Mailing Address:_____

Responsible Party's Employer:_____

Do you have a **Secondary** Insurance:_____

2nd Responsible Party's Social Security #/ID/Birthdate:_____/_____

2nd Insurance Claims Mailing Address:_____

I hereby authorize the release of any medical information to process my insurance. I authorize payment to provider and understand I will be billed for any non-covered services.

_____

SignatureDate

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