William L Knox D.D.S.

Patient Information

Drivers License#: ____________________ Pharmacy Name: ____________________#: ___________
Name: ________________________________ Preferred Name: _______________________________
Date of Birth: _________________Social Security#: ___________________Married__ Single__ Child__
Phone (home): ____________________ (work): ____________________ ext:.: ____________________
E-Mail Address: _____________________ Pager#: ________________ Cell Phone: ________________
Home Address: ____ Apt.#: ____________________
City: ____ State: _____ Zip: _________
Employed By: ____ Since: ____________________
Position: ____
Business Address: ____
REFERRED BY: ____

Health Information

Blood Pressure: ____

Have you had or do you have any of the following? (Please circle those that apply)

Anemia	Diabetes	Hepatitis A-B-C-D-E-Q	Transplant/Prostheses
AIDS (HIV) Positive	Epilepsy	High Blood Pressure	Rheumatic Fever
Arthritis/Rheumatism	Glaucoma	Joint Replacement	Recent Surgeries
Asthma	Heart Disease	Pacemaker	Tuberculosis
Cold Sores	Heart Murmur	Radiation Treatment	Chemical Dependency

Do you have any Metal allergies? .... Yes No
Are you Anxious about your appointment? .... Yes No
Are you pregnant? Yes No If so, due date: ____________
DO YOU HAVE ANY DRUG ALLERGIES? .... Yes No
Do you currently use tobacco? Yes No If so, how long? ____________
Have you ever had any complications or allergic reactions following dental treatment? .... Yes No
If yes, please explain: ____

Name of primary Physician: ____ Phone: ____________
Are you presently taking any medications, (including birth control)? .... Yes No
Please list: ____
Are you presently being treated for any disease, condition or problem not listed? .... Yes No
If yes please explain: ____

Previous Dentist: _______________________________________ Date of last dental visit: ____________

Why did you leave your previous dentist?... Yes No
Are you interested in whitening your teeth?.. Yes No
If you could change your smile, what would you do? ____
Do you ever have a bad taste In your mouth? .... Yes No
Are you concerned about snoring? .... Yes No
Have you been treated for TMJ? .... Yes No
Have you been treated for Periodontal Disease? .... Yes No

Name of Insured: :____is insured a patient? Yes No
Insured's Birth Date: ______________Social Security #_________________Group#______________
Insured's Employer: ____
Patient's relationship to insured: ____
Dental Ins. Carrier Name :____
Dental Ins. Carrier Add: ____

* Please read and sign to have our office file your Insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Dr. Bill Knox or Dr. Amy N. Bender, of the group insurance benefits otherwise payable to me.

Signature:____Date:_________________

SECONDARY INSURANCE IS THE RESPONSIBILITY OF THE PATIENT/EMPLOYEE

Your initial visit and routine hygiene services are to be paid at the time of service. Ins. will be filed to reimburse you.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education and training.

I have read the above conditions of treatment and payment and agree to their content.

____ ______________ _______________________
Signature of patient, parent or guardian Date Relationship to Patient