Kenneth Holzknecht, DMD

Date: _____

PATIENT INFORMATION:

Last Name | First | Middle | Maiden Name

Home Address | Mailing Address (If Different)

City | State | Zip Code

Date of Birth | Sex | Social Security No. | Home Phone | Cell Phone

Driver's License No. | State of Issue | Email Address | Marital Status

Place of Employment | Occupation | Work Phone

Spouse/Parent | Home Address | Social Security No.

Spouse/Parent Place of Employment | Occupation | Date of Birth | Work Phone

Other Family Members Seen in Our Office _____

Referred By: _____

INSURANCE INFORMATION

(Please Give Your Insurance Card To The Receptionist)

Patient's Relationship to Subscriber | Name of Dental Insurance Company

ID No.. | Group # | Address of Insurance Company

City | State | Zip Code

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not living at same address) | Relationship to Patient | Home Phone | Work Phone

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment of any services rendered prior to those services being performed. I also authorize Dr. Holzknecht, his staff or insurance company to release any information required to process my claims. You must realize that your insurance company has an obligation to you and not to the dentist. This office has no contractual arrangements with insurance carriers, unions, or managements; therefore you are responsible to us for payment of services rendered.

_____ _____

PATIENT/GUARDIAN SIGNATURE (REQUIRED) DATE