DR. JEFF KNUTZEN
Excellence in Family & Cosmetic Dentistry

6260 El Camino Real, Suite #205
Carlsbad, CA 92009
(760) 438-8353

PATIENT INFORMATION

"Welcome and thank you for choosing our office to care for you. We will strive to provide you with the best possible care. To help meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us, we are here to help." - Dr. Jeff Knutzen

PATIENT INFORMATION

Name: _____ Birth Date: _____

Prefer to be called: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Full time student: YES or NO (circle one)

Employer: _____ Occupation: _____

Spouse: _____ Spouse Employer: _____

Person Responsible for Account: _____ Phone: _____

Person to contact in case of an emergency: _____ Phone: _____

Who may we thank for referring you? _____

How long has it been since your last visit to the dentist? _____

INSURANCE INFORMATION (please provide your insurance card and photo ID for additional information)

Dental Ins Co: _____ Phone: _____ Group #: _____

Policy Holder: _____ Birthdate: _____ ID #: _____

Name of Employer: _____ Phone: _____

Relationship: SELF SPOUSE CHILD (circle one)

Secondary Insurance: _____ Phone: _____

AUTHORIZATION AND RELEASE

I certify that I have read and understand that the above information, and that the information I provided is accurate. I will inform the office upon any change with my contact information and/or insurance coverage information. I have reviewed the offices written financial policy including acknowledgement of the appointment cancellation policy. I authorize Jeff Knutzen, DDS to release any information regarding examination, diagnosis, and treatment rendered to me or my dependent to third party payers and/or health practitioners. I understand that Dr. Knutzen's team will make every effort to estimate the amount insurance will cover accurately and I understand that my dental insurance carrier may pay less than the actual fee for service. I agree to and understand that I am ultimately responsible for payments for all services rendered on my behalf or my dependents.

Signature _____ Date _____