## Patient Information

Full name: _____
SSN: _____
Address: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Sex: _____
Birthdate: _____
Married: ☐ Single: ☐ Dependent: ☐ Widowed: ☐

Employer: _____
Occupation: _____
Employer Phone: _____

Spouse's Name: _____
Spouse's Birthdate: _____
Spouse's SSN: _____
Spouse's Phone: _____

In case of emergency:
Name: _____ Relationship: _____
Phone: _____

Referred in by: _____

Who is responsible for this account? _____
Relationship to patient: _____

Insurance company: _____
Group #: _____
Subscriber's name: _____
Subscriber's SSN: _____
Subscriber's DOB: _____
Subscriber's relationship to patient: _____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with _____ _____(name of insurance companies(s) and assigned directly to Dr. White all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of patient, guardian or representative Date