WHITE
FAMILY DENTAL
People you know. People who care.

Patient Information

Patient's Name _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Birthday _____ Social Security # _____

Cell Phone _____ Email address _____

Whom may we "Thank" for referring you to our practice: _____

Responsible Party Information

Name _____

Address _____
Street City State Zip

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Emergency Information

Person to contact / Relationship _____

Complete Address _____

Phone Home _____ Work _____ Cell _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ ID # _____

Insurance Company Address _____

Insured's Employer _____

Do you have dual (2nd) coverage? Yes _____ No _____ If Yes:

Insured's name _____ Insured's Soc. Sec.# _____

Insurance Co. _____ Group # _____ ID # _____

Insurance Co. Address _____

Insured's Employer _____

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for facilitating the billing and reimbursement directly to White Family Dental of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after the treatment, unless other financial arrangements have been previously arranged. I assigned my insurance reimbursement directly to White Family Dental and agree that I am responsible for any unpaid balance should my insurance deny reimbursement. Initial_____

Signature (Parent's signature if minor) _____