Patient Information

name_____married__single__minor__male__female__

address_____
city state zip code email address

telephone_____ _____ _____ employer_____
home cell work

birth date_____SS#_____ Student? Name of School _____

Whom may we thank for referring you to our office?_____

Insurance Information: Do you have Dental Insurance? If yes, please provide the information below
*If you have dual insurance, please ask for a Secondary Insurance Form.

Name of the Insured _____relationship to patient_____

birthdate_____SS#_____ Employer_____

address-if different from patient _____phone #_____

Insurance Company _____Group #_____ ID #_____

address _____ telephone_____

Person to contact in case of an emergency:

name _____

address _____

phone_____relationship_____

Person responsible for account, if other than patient:

name _____

address_____

phone_____ relationship_____

Payment Information: I understand that payment in full at the time of treatment is expected. Payment arrangements may be available if made in advance. If the amount due is not paid in 30 days a service charge in the amount of 1.5% will be added, (annual percentage of 18% applied to the last monthly balance). In case of a default payment,I agree to pay interest on the balance due, any collections costs and reasonable attorney fees to effect collection of this account.

Authorization: I authorize payment of Insurance benefits directly to this dental office. I understand that I am responsible for all costs of dental treatment. I authorize Dr. Charles White's office to administer such medication and perform diagnostic &/or therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical history is correct to the best if my knowledge. I grant Dr. Charles White the right to release as necessary my dental/medical information and information about my treatment to third party payers and other health professionals.

signature_____patient____guardian___ date_____