



# WHITE FAMILY DENTAL

People you know. People who care.

## Patient Information

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

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 \_\_\_\_\_

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 \_\_\_\_\_

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 \_\_\_\_\_

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_