



Confidential Patient Information

Date _____

Patient's Name _____
Last First Middle Initial Preferred Name

Residence _____
Street City State Zip

WHITEANDHAINES
advanced dentistry
general dentistry
Steven M. White DDS, PA
Brad S. Haines DDS, PA

Mailing Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Cellular Phone _____ Email _____

Social Security # _____ Birthdate _____ Marital Status _____

Employer _____ Occupation _____

Spouse's Name _____ Birthdate _____
Last First Middle Initial

Social Security # _____ Employer _____ Occupation _____

Work Phone _____ Cellular Phone _____ Email _____

If patient is a minor, give parent's or guardian's name _____

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

Confidential Responsible Party/Guarantor Information

Name _____ Relationship to Patient _____
Last First Middle Initial

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cellular Phone _____

Birthdate _____ Social Security # _____ Marital Status _____

Employer _____ Occupation _____

Dental Insurance Information

Policy Holder's Name _____ Social Security/ID # _____ Birthdate _____

Insurance Company _____ Group # _____

Address _____ Phone _____
Street City State Zip

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes, please provide information upon check-in.

Emergency Information

Name of nearest relative/person not living with you _____

Address _____
Street City State Zip

Home Phone _____ Cellular Phone _____ Work Phone _____ Relationship _____

x _____
Patient Signature

_____ Date