DEBORAH J. WHITE, M.D., PC

Plastic and Reconstructive Surgery

Personal Information ***Today's Date*** _____

Last Name:_____ **First:** _____ **MI:**_____

How do you wish to be addressed? _____

Date of Birth:_____ **Age:**_____ **Soc. Sec #:**_____

Marital Status: M:_____ **S:**_____ **D:**_____ **W:**_____ **Sex: F:**_____ **M:**_____

Occupation:_____ **Spouse's name:** _____

Home Address:_____

City_____**State**_____**Zip**_____

Home ph: (_____**)**_____**Cell Ph: (**____**)**_____**Email** _____

Place of Employment:_____ **Work: (**___ **)**_____

Whom Shall We Notify In Case of Emergency: _____
OTHER THAN SPOUSE

Ph. #: (____**)**_____ **Relationship to Patient:** _____

We appreciate your visit with us today and if you were referred to our office, kindly let us know by name whom we can thank: _____

Briefly state the reason for your visit with us today: _____

_____

AUTHORIZED SIGNATURE: ***I authorize payment of medical benefits to Deborah J. White, M.D. for any care rendered to myself or my dependents. I understand I am responsible for any bills. I also authorize Deborah J. White, M.D. to release any medical or other information necessary to process any claims relating to my medical care rendered by her.***

SIGNATURE: _____ **DATE:** _____

I agree to give Dr. White a copy of my drivers license to protect myself from any form of patient identity theft.
SIGNATURE:_____ **DATE:**_____

If my check is returned for any reason, this office is authorized to debit my account for the face amount of the check plus a service fee of $25.00.

SIGNATURE: _____ **DATE:** _____

Please be advised that this office DOES NOT take any form of insurance

THIS OFFICE REQUIRES A COPY OF YOUR INSURANCE CARD FOR HOSPITAL PURPOSES ONLY