Deborah J. White, MD PC
Aesthetic & Reconstructive Surgery

Personal Information Today's Date _____

Last Name:_____ First: _____ MI:_____

How do you wish to be addressed? _____

Home Address:_____

City_____State_____Zip_____

Hm: (_____)_____Cell: (_____)_____ Email _____

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

Marital Status: M:____ S:____D:____ W:____ Spouse's name: _____ Sex: F:____ M:____

Place of Employment:_____Occupation:_____ Wk: (_____)_____

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****