PATIENT INFORMATION — DR. LOUIS WHITE, D.P.M.

NAME _____ BIRTHDATE _____

ADDRESS _____ CITY _____ ZIP _____

PHONE # _____ CELL PHONE # _____ WORK PHONE # _____

E-MAIL ADDRESS _____

AGE ____ M__ F__ MARITAL STATUS: S M W D REFERRED BY _____
How did you hear about us? (circle) Paper Phone book Dr. Relative Friend Online Web site Other _____

EMPLOYER _____ OCCUPATION _____

SPOUSE/PARENT'S NAME _____ SPOUSE/PARENT'S BIRTHDATE _____
SPOUSE/PARENT'S EMPLOYER _____ SPOUSE/PARENT'S WORK # _____

PLEASE LIST AN ADDITIONAL CONTACT PERSON LIVING AT A DIFFERENT ADDRESS:
NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____ WORKPHONE _____

INSURANCE INFORMATION:
POLICY HOLDER'S NAME _____ BIRTHDATE _____ SS# _____
INSURANCE COMPANY CONTRACT # GROUP #
1. _____
2. _____
NOTE: We will bill 2 insurance companies. You will need to submit to additional companies.

PERSON RESPONSIBLE FOR BILL IF OTHER THAN LISTED ABOVE:
NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE # _____
EMPLOYER _____ WORK PHONE # _____

AUTHORIZATIONS:
I authorize payment be made directly to the physician for medical/surgical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance. I authorize the release of information for insurance claim purposes; this may include information regarding the patient's health status, including information regarding any communicable diseases, venereal diseases, HIV or AIDS. I give permission for the release of insurance information for billing purposes to any lab which is associated with my treatment. I give permission for the doctor's office to leave messages at my home, work, or electronically to my e-mail address listed above, regarding medical information they deem necessary, such as, but not limited to, appointment reminders or requests for the patient to contact our office. I consent to medical treatment recommended by Dr. White.

Do you have an advanced directive? ___Yes ___ No

To insure your privacy please list any family members or other persons, if any, whom you give permission for us to release information to regarding you medical condition or diagnosis.

_____

_____

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THAT THE INFORMATION GIVEN IS CORRECT
Please verify your copay. Co-pays are due at the time of the visit. Valid insurance information must be presented at each visit, you may receive a bill for services rendered if not covered or incorrect information is provided.

SIGNED _____ DATE _____