Welcome…

White Smiles Pediatric Dentistry

TRAVIS R. WHITE, DMD

CHILDS NAME: First_____ Last_____ Male / Female
Birthdate:_____ Age:_____Social Security Number: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Child lives with: □Father □ Mother □Both □ Other
Marital Status of Parents: □Married □Single □ Divorced □Separated □Widowed

FATHER: _____Home Phone: _____Cell Phone: _____
Birthdate: _____ Social Security Number: _____
Father's Employer: _____ Work Phone: _____
Home Address if different from child: _____
E-mail Address: _____

MOTHER: _____Home Phone: _____Cell Phone: _____
Birthdate: _____ Social Security Number: _____
Mother's Employer: _____ Work Phone: _____
Home Address if different from child: _____
E-mail Address: _____

If appropriate – Name of Legal Guardian:_____ *Phone*: _____

PERSON FINANCIALLY RESPONSIBLE: _____
If other than parent please write address: _____
Home Phone: _____ Cell: _____Work: _____

PAYMENT OPTIONS: Method of payment (please check)
□ Cash □Care Credit □Credit Card □ Insurance + balance due □Medicaid

PRIMARY DENTAL INSURANCE:
Subscriber name: _____
Insurance company: _____

SECONDARY DENTAL INSURANCE:
Subscriber name: _____
Insurance company: _____

****Please bring all Insurance cards with you to your appointment***

REFERRAL INFORMATION: Who may we thank for referring you to our office?
Physician / Dental Office: (Doctor's name) _____
Another Patient: (name) _____ Friend: (name) _____
School: _____Work: _____ Other: _____

EMERGENCY CONTACT: (specify someone who does not live in your household.)
Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____

ASSIGNMENT AND RELEASE:
I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Travis R. White, DMD, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature: _____ Date: _____ Relationship: _____

Please print name of Patient, Parent, Guardian / Personal Representative: _____