WHITE OAKS DENTAL

Patient Information

____
First Name Middle Initial Last Name Preferred Name (Nickname)

Address: ____ ☐ Single ☐ Married ☐ Minor ☐ Male ☐ Female
Street City State Zip

Phone: ____ Birthdate: ________________________
Home Cell Work

Email: ____ Social Security #: ____________________________________

Emergency Contact Name: ____ Phone: ______________________________

Person Responsible for Account (if patient is under 18): ____

Primary Insurance Information

Dental Insurance Company: ____

Subscriber ID: ____ Group#: ____

Insured Name: ____ Birthdate: _____________________ SS #: __________________

Address: ____

Insured Employer: _______________________________________ Relationship to Patient: ______________________________

Secondary Insurance Information

Dental Insurance Company: ____

Subscriber ID: ____ Group#: ____

Insured Name: ____ Birthdate: _____________________ SS #: __________________

Address: ____

Insured Employer: _______________________________________ Relationship to Patient: ______________________________

Authorization

I hereby authorize payment directly to White Oaks Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize White Oaks Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. I understand that it is my responsibility to provide updated information to White Oaks Dental if/when changes occur. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers by any method, including electronic transfer.

Signature of Patient/Responsible Party: ____ Date: ____________________