



WHITE HOUSE DENTAL

BERNT E. WHITE, D.M.D.

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Welcome to our office! Please help us by filling out the following form with your dental/health history and billing information. Thank you!

Patient Information:

Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: (____) _____ Email Address: _____

Confirm appointment by text? Yes _____ No _____

If yes, what phone carrier do you have? (Example: Sprint/Verizon/Alltel): _____

How would you prefer to be contacted for Appointment reminders?

Text Home Phone Work Phone Cell Phone E-mail

Date of Birth: _____ Soc. Sec. # _____

Marital Status: married single Sex: male female

Your Employer: _____

You're Employer Address: _____

Spouse Name: _____ Spouse Employer: _____

Primary Insurance:

Person Responsible for Account:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Soc. Sec. # _____

Employer: _____

Employer Address: _____

Dental Insurance Co.: _____

Address: _____

Additional Insurance:

Is patient covered by additional insurance YES NO

Subscriber Name: _____

Relationship to Patient: _____ Employer: _____

Address (if different from patient) _____

City: _____ State: _____ Zip: _____ Phone: _____

Soc. Sec #: _____ Date of Birth: _____

Insurance Company: _____

Financial Responsibility:

As a courtesy to our patients, we will submit dental claims for insurance payment. Please be aware, however, that in the event your insurance company does not cover charges incurred, the **responsible party will be held liable for the balance owing on the account.** In case your dental insurance coverage has changed, please be sure to update us with your current dental insurance information! If you are not covered by an insurance you are responsible for the bill at each appointment.

Method of Payment:

Payment is due at time of service. Methods of Payment our office accepts are: **Cash, Personal Check, Money Order, VISA/Mastercard, and CareCredit.** **We also have a payment plans that allows you to start treatment today with no down payment, and spread payment over time.** You need to apply for the payment plans we have CareCredit and Citi Health Card, if you would like to apply please as for application. If you are covered by Dental Insurance, you are responsible for your percentage at the time of service and we will bill the insurance for the balance. Our bills will go out every month if your balance is 60 days past due you will automatically receive a finance charge of 1.5%. (Please read **Financial Responsibility** paragraph above.)
Any other financial arrangements MUST be made PRIOR to treatment!

Authorization:

I hereby authorize payment of my dental insurance benefits otherwise payable to me to Dr. Richard White/Dr. Bernt White. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Richard White/Dr. Bernt White to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page are correct to the best of my knowledge.

Signature of Responsible Party: _____

Date: _____

Health information and History

Patients Name: _____ Date: _____
 Emergency Contact: _____ Phone: _____ Relationship: _____
 Primary Physician: _____ Phone: _____ City & State: _____
 Are you under a doctors care now? (describe): _____

- | | Yes | No |
|--|-----|-----|
| 1.) Have you been hospitalized or had surgery in the last 3 years?
Explain: _____ | ___ | ___ |
| 2.) Have you been instructed to take any medication or take any special precautions, before any dental appointments? | ___ | ___ |
| 3.) Are you taking any drugs, medication or having treatment at this time?
Please list: _____

_____ | ___ | ___ |
| 4.) Are you allergic to any medications, drugs or treatment?
Please list: _____ | ___ | ___ |
| 5.) Are you allergic to Latex? | ___ | ___ |
| 6.) Are you taking or have you taken a Bisphosphonate (Fosamax)? | ___ | ___ |
| 7.) Are you pregnant? (Women) | ___ | ___ |
| 8.) Are you currently taking any anti-depressants?
If yes, please list: _____ | ___ | ___ |

Please circle if you have any of the following:

- | | | |
|-------------------------------|-------------------------|-----------------------------|
| Scarlet fever | Low Blood Pressure | Mitral Valve Prolapse |
| Arthritis/Gout | High Blood Pressure | Parathyroid Disease |
| Rheumatic Fever/heart disease | Frequent Cough | Bruise Easily |
| Pacemaker | Tuberculosis | Thyroid Disease |
| Emphysema/lung disease | Excessive Thirst | Rheumatism |
| Blood Disease | Liver Disease | Pain in Jaw Joints |
| Anemia | Hepatitis A | Cortisone Medication |
| Shortness of Breath | Hepatitis B | Glaucoma |
| Swelling of Feet/Ankles/Hands | Hepatitis C | Epilepsy or Seizures |
| Yellow Jaundice | Hypoglycemia | Drug Addiction |
| Recent Weight Loss | Chest Pain | Blood Transfusion |
| Dizziness | Heart Trouble | Hemophilia |
| Lung Disease | Skin problems | AIDS/HIV |
| Diabetes | Heart Defect | Venereal Disease |
| Heart Murmur | Herpes | Active STD's |
| Kidney Trouble | Stroke/CVA | Cancer |
| Ulcers/Acid reflux | Artificial Heart Valve | Chemotherapy |
| Sinus Trouble | Allergies | Radiation |
| Alzheimers or Dementia | Osteoporosis | Atherosclerosis |
| Congestive heart failure | Coronary artery disease | Heart attack When _____ |
| Heart surgery When _____ | Excessive bleeding | Organ Transplant |
| Asthma | Light Sensitivity | Dry Mouth |
| Mental Health Issues | Artificial Joints | What joint _____ When _____ |

8.) Do you have any other conditions, diseases, or medical problems not listed? Yes No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at my next appointment without fail.

Signature _____ Date _____