NICKNAME or NAME YOU PREFER ______________________________

PATIENT ______________________ AGE ______ BIRTH DATE ___________ Drivers License # STATE/EXP______________

HOME PHONE # (_____) ____________ WORK PHONE # (_____) ____________ CELL PHONE # (_____) ____________

ADDRESS ____
NO. STREET APT. NO. CITY STATE ZIP

E-MAIL ADDRESS ______________________________

MARRIED __________ DIVORCED ___________ SINGLE __________ WIDOW __________ SOCIAL SECURITY NO. ______________

PATIENT'S EMPLOYER ______________ SPOUSE'S NAME ______________ BIRTH DATE ____________

SPOUSE'S EMPLOYER ______________SPOUSE'S SOCIAL SECURITY # ______________

SPOUSE'S WORK PHONE # (_____) ____________CELL PHONE # (_____) ____________ Drivers License # STATE/EXP ____________

EMERGENCY CONTACT______________ RELATIONSHIP______________ PHONE (_____) ____________

REFERRED TO THIS OFFICE BY ______________________ PHONE (_____) ____________

PREFERRED PHARMACY ____________ PHONE ____________ FAX ____________

OTHER MD'S ____________ PHONE ____________ FAX ____________

____________ PHONE ____________ FAX ____________

APPOINTMENT PREFERENCES DAY OF THE WEEK ____________ TIME OF DAY ____________

NOTICE! ***Patient is responsible for all office fees at time services are rendered.***
All insurance information must be provided when appointment
is made or your appointment will be rescheduled.

OFFICE USE ONLY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby permit Kathryn White, MD to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

Patient Signature ______________________ Date Signed ______________________