



**Deborah J. White, MD PC**  
**Aesthetic & Reconstructive Surgery**

Personal Information

Today's Date \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

How do you wish to be addressed? \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Hm: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec #: \_\_\_\_\_

Marital Status: M: \_\_\_\_\_ S: \_\_\_\_\_ D: \_\_\_\_\_ W: \_\_\_\_\_ Spouse's name: \_\_\_\_\_ Sex: F: \_\_\_\_\_ M: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_ Wk: (\_\_\_\_) \_\_\_\_\_

Whom Shall We Notify In Case of Emergency: \_\_\_\_\_

OTHER THAN SPOUSE

Ph. #: (\_\_\_\_) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

We appreciate your visit with us today and if you were referred to our office, kindly let us know by name whom we can thank:

\_\_\_\_\_

Briefly state the reason for your visit with us today: \_\_\_\_\_

\_\_\_\_\_

**AUTHORIZED SIGNATURE: I authorize payment of medical benefits to Deborah J. White, M.D. for any care rendered to myself or my dependents. I understand I am responsible for any bills. I also authorize Deborah J. White, M.D. to release any medical or other information necessary to process any claims relating to my medical care rendered by her.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

I agree to give Dr. White a copy of my drivers license to protect myself from any form of patient identity theft.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

If my check is returned for any reason, this office is authorized to debit my account for the face amount of the check plus a service fee of \$25.00.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**\*\*Please be advised that this office DOES NOT take any form of insurance\*\***