



5771 South Fort Apache Rd. Ste # 100,
 Las Vegas, NV 89148
 Phone: (702) 951-3400
 Fax (702) 951-3403

PATIENT DEMOGRAPHICS

| PATIENT INFORMATION | | | | |
|--------------------------------|------------|------------|--|-------------------|
| PATIENT NAME (LAST, FIRST, MI) | HOME PHONE | CELL PHONE | | |
| MAILING ADDRESS | | | | |
| DATE OF BIRTH | AGE | SEX | MARITAL STATUS: Single Married Divorced Separated Widowed | SOCIAL SECURITY # |

| EMPLOYMENT INFORMATION | | | |
|------------------------|------------|------------|--|
| PATIENT'S EMPLOYER | OCCUPATION | WORK PHONE | |
| WORK ADDRESS | | | |

| SPOUSE INFORMATION | | | |
|------------------------|------------|------------|------------|
| NAME (LAST, FIRST, MI) | DOB | SS# | HOME PHONE |
| ADDRESS | | | |
| CITY | STATE | ZIP | |
| EMPLOYER | OCCUPATION | WORK PHONE | |
| WORK ADDRESS | | | |

| INSURANCE INFORMATION | | |
|---|-------------------------|---------------------------|
| *In order to properly bill your insurance company, this section must be completed, or you may be responsible for your medical bills. | | |
| INSURANCE NAME | | |
| POLICY HOLDER NAME | DATE OF BIRTH | SOCIAL SECURITY # |
| RELATIONSHIP TO PATIENT | POLICY HOLDERS EMPLOYER | |
| POLICY # | GROUP # | EFFECTIVE DATE (IF KNOWN) |

| EMERGENCY CONTACT | | |
|-------------------|-------|--------------|
| NAME | PHONE | RELATIONSHIP |

I hereby guarantee payment of all charges incurred for this account. I understand that my insurance, if any, can be applied to my bill. If there is a balance on my account not covered by insurance, I agree to pay this amount. If it becomes necessary to collect this account, I agree to pay any additional costs of collections, including attorney fees. I hereby consent to treatment by Sanford F. White, M.D. and assign all benefits for medical services to be paid directly to named physician. I hereby authorize the release of any medical information required by insurance companies in connection with the above assignment.

Responsible Party Signature

Date

Referred by: Family Member Friend Mailer Provider List Walk-In Other: _____