Sanford F. White, M.D., M.P.H.
5771 South Fort Apache Rd. Ste # 100
Las Vegas, NV 89148
Phone: (702) 951-3400
Fax (702) 951-3403

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI)			HOME PHONE
MAILING ADDRESS			
DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY #

PARENT/RESPONSIBLE PARTY INFORMATION

	Mother	Father
NAME		
DATE OF BIRTH		
HOME PHONE		
CELL PHONE		
MAILING ADDRESS		
SOCIAL SECURITY #		
EMPLOYER		
OCCUPATION		
WORK ADDRESS		
WORK PHONE		

INSURANCE INFORMATION

***In order to properly bill your insurance company, this section MUST be completed, or you may be responsible for any medical bills.**

INSURANCE COMPANY		
POLICY HOLDER NAME	DATE OF BIRTH	SOCIAL SECURITY #
RELATIONSHIP TO PATIENT	POLICY HOLDERS EMPLOYER	
POLICY #	GROUP #	EFFECTIVE DATE

Pediatric Patient Demographics

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:________________________