



WHITE OAK
DENTAL
NEW PATIENT INTAKE

PERSONAL INFORMATION

Patient's Name: _____

Address: _____

City: _____

State/Zip: _____

E-mail: _____

Did someone refer you to us? If so, please tell us who? _____

If you are the parent or guardian of a minor visiting us today, please tell us about yourself?

Parent/Guardian Name: _____

Address: _____

City/State/Zip: _____

E-mail: _____

Drivers License #: _____

Social Security #: _____

Date of Birth: _____

Cell Phone: _____

Home Phone: _____

() Male () Female () Prefer Not To Say

() Single () Married

Spouse's Name: _____

EMPLOYER INFORMATION

Employer Name: _____

Employer Address: _____

City/State/Zip: _____

If Student, School Name: _____

Grade: _____

Business Phone: _____

Occupation: _____

Business E-mail: _____

INSURANCE INFORMATION

Name of Insured Person: _____

Insured Date of Birth: _____

Name of Insurance Co: _____

Social Security # of Insured: _____

Plan Name or #: _____

Group # / Effective Date: _____

If you have additional insurance please complete the following:

Name of Insured Person: _____

Insured Date of Birth: _____

Name of Insurance Co: _____

Social Security # of Insured: _____

Plan Name or #: _____

Group # / Effective Date: _____

Patient or Guardian's Signature: _____ **Date:** __/__/__