The Medical Profession, LLC
Robin S. White, M.D.
5301 Reno Corporate Dr.
Reno, NV 89511
775-329-5555

Patient Intake Form

Date:____

PATIENTS NAME: ____ M / F Sibling names: _________________________________

Address:____City:_____________________ State:_____________ Zip:________________

DOB:___________________ Home Phone:_______________________________E-Mail____

MOTHER'S NAME: ____ Cell Phone:__________________________________

Address:____City:_____________________ State:_____________ Zip:________________

DOB:__________________________________ Employer: ______________________________ Work Phone: ______________________

FATHER'S NAME: ____ Cell Phone: _______________________

Address:____City:_____________________ State:_____________ Zip:________________

DOB:__________________________________ Employer:_____ _________________________ Work Phone: ______________________

EMERGENCY CONTACT: ____ Phone: ______________________

Insurance Information - Policy covering Patient (Your Child)

Is this policy through an employer? YES / NO If yes, name of employer: ___________________________________+________________

Insurance Company: ____ Co-Pay: $_____________________________

Ins. Co. Address:____City:_____________ State:___________ Zip:___________

Ins. Co. Phone: ____ Group Policy Number: _____________________________

Subscriber name: ____ Subscriber ID#________________________________

Subscriber SSN: ____ Patient/Child ID# ______________________________________

I understand that Dr. White ***does not*** bill secondary insurance policies. Once the primary insurance pays, I am responsible for any remaining balance.

I understand that if Dr. White ***does not*** have a contract with my insurance company, I hereby authorize direct payment of medical benefits to Dr. White for services rendered by her. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize Dr. White to release any medical or incidental information that maybe necessary for other medical care OR in the processing of applications for financial benefits.

A photocopy of the assignments shall be valid as the original.

WE WIL BE COLLECTING COPAYS AND BALANCES AT TIME OF SERVICE. PLEASE BE PREPARED WITH PAYMENT.

Signature of parent/guardian: ____