

West Chester Dental Group

Patient Registration

Patient Information (Confidential)	Date _____				
Name _____	I prefer to be called _____	Birth date _____			
(First)	(MI)	(Last)			
<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Single	<input type="checkbox"/> Married	Social Security # _____	Driver's License # _____
Address _____	_____	_____	_____	_____	_____
(Street)	(City)	(State)	(Zip)		
Phone Numbers (List All) _____	_____	_____	_____	_____	_____
(Home)	(Work)	(Cell)	(Other)		
Employer _____	Occupation _____				
Whom may we thank for referring you? _____					
Other family members seen by us _____					
Person to contact in case of emergency? _____	Phone _____				

Spouse Information		
Spouse _____	Birth date _____	Soc Sec # _____
Employer _____	Occupation _____	

Responsible Party
Name on Account (Whose name is to appear on billing statements?) <input type="checkbox"/> My Name <input type="checkbox"/> My Spouse's Name

Confirming Appointments
We prefer to confirm appointments by email. Please list your email address here _____
If you do not have email or do not check it regularly, please list the best phone number to reach you during the day _____

Insurance			
If you will be using dental insurance, please show your dental insurance card/s to the receptionist for verification of benefits.			
Name of Primary _____	Subscriber # _____	Self	Spouse
Secondary _____	Subscriber# _____	Self	Spouse

Authorizations and Signatures	
I authorize West Chester Dental Group to release any information - including the diagnosis and records - of any treatment or examination rendered to me or my child to third party payors and/or health practitioners and to use my signature as needed on all insurance submissions. I authorize and request my insurance company to pay directly to the West Chester Dental Group insurance benefits otherwise payable to me. I understand that I am responsible for estimated deductibles and co-payments at time of service and for all payments of services rendered, regardless of estimates or insurance payments. I agree to be responsible for payment of all services rendered on my behalf or my dependents.	
Signature _____	Date _____