West Chester Dental Group

Patient Registration

Patient Information (Confidential) **Date** ____________________

Name ______________________ I prefer to be called __________ Birth date __________
(First) (MI) (Last)

☐ M ☐ F ☐ Single ☐ 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?) ☐ My Name ☐ 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 ______________

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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 ______________________