Dental Specialties of West Chester

Child Registration

Patient Information (Confidential) **Today's Date** _____

Name_____I prefer to be called_____
(First) (MI) (Last)

Birthdate_____/_____/_____ ☐ M ☐ F School _____

Address _____
(Street) (City) (State) (Zip)

Whom may we thank for referring you? _____

Other family members seen by us_____

We prefer to confirm appointments through email. If this works for you, please list an email address _____ If you do not have email or do not check it regularly, please list the best phone number to reach you during daytime hours. _____

Father Information (or Legal Guardian)

Father_____

Birthdate_____ Soc Sec #_____Drivers Lic #_____

Address _____
(Street) (City) (State) (Zip)

Phone Numbers _____
Home Work Cell Other

Employer_____Occupation_____

Address_____

Mother Information

Mother_____

Birthdate_____ Soc Sec #_____Drivers Lic #_____

Address _____
(Street) (City) (State) (Zip)

Phone Numbers _____
Home Work Cell Other

Employer_____Occupation_____

Address_____

Responsible Party

Name on Account (Whose name is to appear on billing statements?) ☐My Father's Name ☐My Mother's Name

Insurance **Subscriber** _____ **Name of Plan** _____

If you will be using dental insurance, please show your dental insurance cards to the receptionist for verification of benefits.

Please understand that *estimated* co-pays are due at time of service and that entire balance is your responsibility.