West Chester Dental Group
Child Registration

Patient Information (Confidential) **Date_____**

Name_____ Preferred name_____
(First) (MI) (Last)

Birthdate_____/_____/_____ M____ F____ School _____

Home Address_____
(Street) (City) (State) (Zip)

Whom may we thank for referring you?_____

Other family members seen by us_____

Father_____

Birthdate_____/_____/_____Social Security #_____

Address (if different from child's address) _____

Phone Numbers_____
(Home) (Work) (Cell)

Employer_____

Mother_____

Birthdate_____/_____/_____Social Security #_____

Address (if different from child's address) _____

Phone Numbers_____
(Home) (Work) (Cell)

Employer_____

Responsible Party

Name on Account (Whose name is to appear on billing statements?) _____Father _____Mother

Insurance Subscriber_____ Name of Plan_____

If you will be using dental insurance, please show 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.