DENTAL SPECIALTIES of West Chester

Patient Registration

Patient Information (Confidential) **Date** _____ **Date of Birth** _____

Name _____ Preferred Name or Nickname _____
First MI Last

☐ Male ☐ Female ☐ Single ☐ Married **Social Security #** _____ **Driver's License #** _____

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

Phone Numbers (List All) _____ _____ _____ _____
(Home) (Cell) (Work) (Other)

We prefer to confirm appointments by email. Please list your email address here _____

Employer _____ **Occupation** _____

How did you hear about us? _____

Are other family members seen at our office? _____

Person to contact in case of an emergency? Name _____

Relation _____ Phone Number _____

Spouse Information

Name _____ **Date of Birth** _____ **Social Security #** _____

Employer _____ **Occupation** _____

Responsible Party

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

Insurance

Please show your dental insurance card(s) to the receptionist for verification of benefits.

Name of Primary Insurance _____ **Subscriber #** _____

Name of Secondary Insurance _____ **Subscriber #** _____

I authorize Dental Specialties of West Chester to release any information- including the diagnosis and records- of any treatment or examination rendered to me or my child to third party payer(s) 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 Dental Specialties of West Chester, insurance benefits otherwise payable to me. I understand that I am responsible for the estimated deductible and co-payments at the time of services rendered on my behalf or my dependents.

Signature _____ **Date** _____