DENTAL SPECIALTIES
of West Chester

Patient Registration

Child/ Dependent

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

Name _____ Preferred Name or Nickname _____
First MI Last

☐ Male ☐ Female **School Name** _____

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

We prefer to confirm and inform you of any changes regarding an appointment by email.

Please list the best email in which to contact you: _____

General Dentist's Name _____ **Phone #** _____

Pediatrician/ Primary Care Doctor's Name _____ **Phone#** _____

How did you hear about us? _____

Are other family members seen at our office? _____

Father's Information (or Legal Guardian)

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

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

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

Employer _____ **Occupation** _____

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

Mother's Information (or Legal Guardian)

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

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

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

Employer _____ **Occupation** _____

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

Responsible Party

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

Insurance

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

Subscriber's Name _____ **Name of Plan** _____