

PEDIATRIC Account Registration Form

Print it out, Fill in Information and Fax to: 610-337-3863 - Or bring with you to appointment.

Mother's Name Or Guardian		Home Tel#	
Address			
Email		Cell #	
Mother's DOB		Mother's SS#	
Employer		Work Tel#	
Work Address			
Father's Name or Guardian		Home Tel#	
Address			
Email		Cell #	
Father's DOB		Father's SS#	
Employer		Work Tel#	
Work Address			
Who is accompanying the child today?			
Name		Relationship to Child	
Emergency Contact Person & Tel #			
Do you have legal custody of this child?	Yes	No	
Whom may we thank for referring you?			
Enter Names/Ages of other Children			
Dental Insurance Information			
Primary Insurance Co.		Group #	
Employee		ID#	
Secondary Insurance Co.		Group #	
Employee		ID#	

I hereby authorize payment directly to the dentists of Upper Merion Dental Associates of the group insurance benefits otherwise payable to me.

X _____ (Insured's Signature)

It is the policy of our office that the parent or guardian who accompanies the child and requests treatment is responsible for payment of all fees at the time of service unless prior arrangements have been approved. In case of default of this account, I agree to pay collection costs on the outstanding balance.

X _____ (Signature of Parent/Guardian)