WVU CHILDREN'S DENTAL PROGRAM

Patient Registration Form

Only children with active Medicaid or active WV Chip are eligible for this program.

CHILD'S Name ____
LAST FIRST MIDDLE

CHILD's Date of Birth ____________________ Age ________ Male________Female________
Month – Day – Year of Child's Birth

Parent/Guardian email address ______________________________________

Child's PO Box or Street Address ______________________________________

City ______________________________, WV Zip Code ____________________

Home Phone ____________________ Cell Phone ____________________

School child will be attending: ____________________ Grade ____________

Medicaid or CHIP ID Number ______________________________

Does the child have any allergies or medical conditions? ________ Yes ________No

If yes, please list: ______________________________________

I declare that the information that I have given is correct to the best of my knowledge, I understand that it will be held in strict confidence and it is my responsibility to inform this office of any changes in my child's medical status. By signing below, I give my permission to the dental staff to perform any or all of the following as deemed necessary during the school year: dental exam, screening, dental images, cleaning, fluoride treatment, and sealants.

PARENT, please PRINT YOUR NAME here ______________________________

PARENT Signature______________________________ Date ____________________

*****Per HIPAA guidelines, all information will be kept private and secure.***

DO NOT WRITE BELOW – FOR DENTAL OFFICE USE ONLY

	Visit 1	Visit 2	Visit 3	Visit 4
	Scion Medi Chip	Scion Medi Chip	Scion Medi Chip	Scion Medi Chip
Last seen WVU For What				
Pvt Dent For What				

Perform Services: