DAG ZAPATERO, D.D.S., M.A.G.D.

General | Cosmetic | Restorative | Implant | Geriatric Dental Care

Patient Registration

Please Print

Date ______________________________

Patient's full name ____________ ____________
First Last

Preferred name ______________________________

( ) Single ( ) Married
( ) Partner ( ) Widowed
( ) Divorced ( ) Dependent Child

Date of Birth ______________________________

Email Address ______________________________

Sex: M◯ F◯

Soc. Sec. # ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone Home ( ) ____________ Work ( ) ____________ Cell ( ) ____________

Patient's Occupation ____________________ Employer ____________________

If patient is a full time student, what school? ______________________________

In case of emergency, please notify: ____________________ Phone ____________
(Friend or relative not living with you)

Referred by: ____________________ Relationship ____________________

Check One: ( ) No Insurance ( ) Insurance ( ) Dual Insurance

Insurance Information Patients relationship to insured: ( ) Self ( ) Spouse ( ) Child

Name of insured ____________________ Employer ____________________

Insurance Co. & Address ____________________ Work Phone ____________ Birthdate ____________

______________________________ Soc. Sec. # ____________ Driver's Lic. # ____________

______________________________ Group # ____________ Employee # ____________

If You Have Dual Coverage, Please Complete for Secondary Carrier:

Name of insured ____________________ Employer ____________________

Insurance Co. & Address ____________________ Work Phone ____________ Birthdate ____________

______________________________ Soc. Sec. # ____________ Driver's Lic. # ____________

______________________________ Group # ____________ Employee # ____________

Name and address of Physician or Clinic ______________________________

Physician's Phone ____________________ Last Medical Exam ____________________

Due to increased use of electronic claims, a permanent record of the patient's assignation of benefits is required. Please read and sign below. Thank you.

I accept treatment as noted and authorize release of information relating hereto. I hereby authorize payment directly to the dentist named on the attached claim of the group insurance benefits otherwise payable to me.

I understand that I am financially responsible for any charges not covered by my insurance benefits.

____
Patient (parent if minor) Signature