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 _____

Preferred phone # ( ) _____ Work / Home ( ) _____ Cell ( ) _____

Patient's Occupation _____ Employer _____

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

In case of emergency, please notify: _____ Relationship _____
(Friend or relative not living with you)

Em. Contact Phone # : _____ Who were you referred by? _____

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