



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 _____

Preferred name _____

First _____ Last _____

Date of Birth _____

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

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 the release of information relating hereto. I hereby authorize payment directly to Dr. Dag Zapatero, 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