



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

3020 Shore Drive, Virginia Beach, VA 23451

PATIENT INFORMATION

Personal Information

Legal name: _____ Wishes to be called: _____

Your birth date: _____ Your Social Security Number: _____

Whom can we thank for referring you? _____ Relationship: _____

Your home address: _____

City: _____ State _____ Zip code: _____

Your phone numbers: Home: _____ Cell: _____ Work: _____

Where do you prefer to receive calls? Home Cell Work What time of day is best to reach you? _____

Your e-mail address: _____

In the event of an emergency, whom should we contact _____

Relationship: _____ Their Phone number: _____

Primary Dental Insurance Holder Information

Holder's Name: _____

Relationship to Patient: _____ Date of Birth: _____

Their Social Security Number/Subscriber Number: _____

Dental Insurance Information

Primary Insurance: _____ Additional Insurance: _____

Employer: _____ Employer's address: _____

Occupation: _____ Group Number: _____

I hereby authorize Dr. Zapatero or his designated team member to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Zapatero to make a thorough diagnosis of my (or my dependent's) dental needs. Upon such diagnosis, I authorize Dr. Zapatero to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete description of any possible complications. I agree that payment is due in full at the time of service unless other arrangements have been made prior to treatment. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder. I understand that the attorney fees are described in full on the Agreement of Payment section on separate cover.

Patient/Guardian Signature Date: _____ Witness: _____

Dag Zapatero, DDS Parent or Guardian responsible for Patient