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

General | Cosmetic | Restorative | Implant | Geriatric Dental Care

PATIENT REGISTRATION

Please Print Date: _____

PATIENT INFORMATION

Patient's Full Name: _____ Preferred Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F ☐ Other Email: _____

Address: _____ City, State, Zip: _____

Preferred Phone: (_____) _____ Cell: (_____) _____

Occupation: _____ Employer: _____

If full-time student, school: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: (_____) _____

Who referred you to our office? _____

INSURANCE INFORMATION

(We electronically file claims as a courtesy. We do **not** participate with any insurance plans.)

☐ No Insurance ☐ Primary Insurance only ☐ Dual Insurance

PRIMARY INSURANCE

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of Insured: _____ Date of Birth: _____

Insurance Company: _____

Group #: _____ Subscriber / Member ID: _____ Employer: _____

SECONDARY INSURANCE (if applicable)

Name of Insured: _____ Date of Birth: _____

Insurance Company: _____

Group #: _____ Subscriber / Member ID: _____ Employer: _____

MEDICAL INFORMATION

Name & Address of Physician / Clinic: _____

Physician's Phone: (_____) _____ Date of Last Medical Exam: _____

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY

Due to the increased use of electronic claims, a permanent record of the patient's assignment of benefits is required. I accept treatment as noted and authorize the release of information relating hereto. I hereby authorize payment of dental benefits otherwise payable to me directly to Dr. Dag Zapatero. I understand that this office does **not** participate with any insurance plans and that I am financially responsible for any charges not covered by my insurance benefits.

_____ _____

Patient (or Parent/Guardian if minor) Signature Date