CONFIDENTIAL

Patient Registration Information **Please Print**

Welcome to our practice!
Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance – we will be happy to help.

Date__________________ Doctor of Preference: ☐Dr. Ralf Zapata ☐Dr. Nathan Hall

Name______________________________________ SSN_________________ ☐Male
First MI Last ☐Female

Home Address___________________________City_____________State_____Zip________

Birthdate_________________Home#____________Work#______________Cell#________

Do you prefer to receive calls at: ☐Home ☐Cell ☐Work Would you like to share you e-mail address with us for appointment conformation only? ☐No ☐Yes E-mail address______________________________

Are you: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Your or your parent/guardian's employer_________________________________Work #_______________

Spouse or Parent/Guardian's name_______________________Employer_______________Work#___________

College students: College______________________City & State____________________Full/Part time________

Person to contact in case of an emergency________________________________Phone#______________

Responsible Party

Name of person responsible for this account______________________________Relationship_______________

SSN_____________ Home#___________ Cell#__________Work#__________Driver's License#___________

Address________________________City__________________State__________Zip____________________

Employer_________________________Is responsible party currently a patient in our office? ☐Yes ☐No

Financial Arrangements

For you convenience, we offer the following methods of payment. Payment in full at each appointment: ☐Cash ☐Personal check ☐Credit Card (Visa, MasterCard or Discover)

There will be a $30.00 Service Charge for all returned checks.

After two missed appointments without 24-hour notification, we may ask that you prepay prior to scheduling your next appointment. Should you miss this third appointment, a $75.00 missed appointment fee will be charged to your account and must be paid, in full, prior to rescheduling any future appointments.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of responsible party____Date____________________

Please complete and sign reverse side

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Insurance Information

Name of Policyholder____Birthdate_________________________

SSN______________ Work#__________ Home#__________ Cell#__________ Relationship to Patient______________

Employer's Name_______________________________________ Date of Employment_________________________

Insurance Company______________________________Employee ID#_______________Group#_________________

Authorization, Release, and Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care the third party payors and/or other health practitioners.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

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Signature of responsible party Date