WELCOME TO OUR OFFICE

WALTER G ZATTERA
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REGISTRATION

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your healthcare needs, please fill out these forms completely. If you have any questions or need assistance, please ask us. We will be happy to help.

PATIENT INFORMATION

Date:_____
Name:_____
Name wished to be called:_____
SSN:_____
Birth Date:_____
Address:_____
City: _____ Zip:_____
Home Phone:_____
Cell Phone:_____
May we send you a text reminder?...Y...N
Email:_____
May we send you an email reminder?...Y...N
Preferred method of contact:_____

Referred By:_____
Emergency Contact:_____

Primary Insurance

Name of Insured:_____
Relation to Patient:_____
Insured's Birth Date:_____
SSN:_____
Employer:_____
Date Employed:_____
Insurance Company:_____
Ins Co. Address:_____
City, State, Zip:_____
Ins Co. Phone #:_____
Group #:_____
Employee #:_____

FINANCIAL ARRANGEMENTS

For your convenience, we accept cash, personal checks, and all major credit cards.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or other health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor:_____