

**DE ZAVALA DENTAL**

**5999 DE ZAVALA RD, # 122  
SAN ANTONIO, TX 78249  
210-691-1333 / 210-561-2599 FAX**

Patient's Name \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_ Drivers License# \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City/St/Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell /Pager # \_\_\_\_\_

E-Mail \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Full- time Student/ Name of school: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Person to contact in case of emergency :**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

**INSURANCE:** We will file all necessary forms & reports to your insurance company. We do not render our services on the basis that the insurance company pay our fee, the patient/patient's guardian is personally responsible for any fee the insurance company does not cover.

Patient Guardian / Insurance Subscriber Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Group# \_\_\_\_\_ Phone # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Group# \_\_\_\_\_ Phone # \_\_\_\_\_

**Please read and initial each one:**

\_\_\_\_ **CANCELLATION POLICY :** There will be a charge for any appointment missed without a 24 hour notice. I understand that I will be responsible for this charge.

\_\_\_\_ **PAYMENT POLICY:** Payment must be made at the time services are rendered unless prior arrangements are made. I understand that I am ultimately responsible for the balance on my account. If I fail to meet the above mentioned requirements, I know this matter will be turned over to an outside collection agency and legal charges may be files against me.

\_\_\_\_ **CONSENT TO TREATMENT: I authorize Dr. Blaess and her staff to perform procedures including, but not limited to prophylaxis (cleaning), taking X-Rays and photographs, administering anesthetics and/or medications, restoring (filling) teeth, removing teeth, endodontics (root canal ) treatment and other procedures he/she may deem necessary for my/my childs proper care.**

**Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_