

DE ZAVALA DENTAL

WWW.DEZAVALA-DENTAL.COM

Patient's Name _____ Gender _____ Marital Status _____

Date of Birth _____ S.S. # _____ Driver's 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 (outside of immediate family / household)

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 appointments 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 requirements, I know this matter will be turned over to an outside collection agency and legal charges may be filed 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 child's proper care.**

Signature : _____ Date: _____