WELCOME TO OUR OFFICE

WALTER G ZATTERA DDS
120 W EASTMAN STREET SUITE 203
ARLINGTON HTS, IL 60004
TEL # 847-394-5620
FAX 847-394-8154
EMAIL WALTERZATTERADDS@GMAIL.COM

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:_____

RESPONSIBLE PARTY

Name:_____
Relationship to Patient: _____
Birth Date:_____
SSN:_____
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

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:_____

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 #:_____

Secondary 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 #:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of HIPAA Notice of Privacy Practices with an effective date of 09/22/2013 which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____

Signature of Patient or Patient's Representative **Date**

_____

Print Name

_____

Relationship to Patient (If not signed by the Patient)