GLAUSER FAMILY DENTISTRY

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

PATIENT INFORMATION	NT INFORMATION Date			
Name	Name you prefer to be called			
Address				_Apt. No
CitySta				
Employer				
Employer Address				
E-Mail address				
□Male □Female SS#/	/Birthday	y//	Drivers Licens	se
☐ Single ☐ Married ☐ Divor	ced Widowed	☐ Minor		
If Student, Name of school		City	DF	ull Time Part Time
Spouse/Parent/Guardian's Name				
Phone				
Whom May We Thank For Refer				
Emergency Contact	Relationshi	pPhone_	(Cell Phone
Best Way To Contact You To Con	firm Appointments			
INSURANCE INFORMATION	v			
Name of Insured	Relation To Patier	ntBirthday		SS#/
Insurance Co		Group No	Phor	ne
ASSIGNMENT AND RELEAS	SE			
I have read and answered the above pay directly to the dentist or dental g information necessary to secure the or not paid by insurance. I authorize can only ESTIMATE my benefits an	roup insurance benefits payment of benefits. I u the use of this signature	otherwise payable to me nderstand that I am finar e on all insurance submi	 I authorize the ncially responsi ssions. I also un 	e doctor to release all ble for all charges whether nderstand that this office
Signature of patient or parent / g		Date		
For your convenience, we offer the		fpayment. Please chec scover Masterca		ou prefer.
□ Cash	n □ Check □ Di	Scover - wrasterea	Iu Visa	