Glaser Dental
24 Brown Boulevard
Rothschild, WI 54474
Phone: 715.359.4344
Fax: 715.359.7733
Email: smile@tylerglaserdental.com

Please complete and bring to appointment

Patient Registration

Glaser Dental requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside Glaser Dental will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in being unable to accept you as a patient.

PATIENT DATA

❑Mr ❑Mrs ❑Rev ❑Ms ❑Miss ❑Dr	Print full legal name: last first middle		
❑Female ❑Male	Date of Birth: *(Month/Day/Year)*	Social Security # :	Preferred Name:
Mailing Address:			
City:	State:	Zip Code:	Email:
Home Phone # *(with area code)*	Work Phone # *(with area code and ext.)*	Cellular Phone # *(with area code)*	Other Phone # *(with area code)*
Best Phone Number to Contact Patient: ❑ Home ❑ Work ❑ Cellular ❑ Other			
Alternate/Permanent Address *(If different than above)*	City:	State:	Zip Code:

EMERGENCY CONTACT INFORMATION *(Required by law)*

Emergency Contact: last first middle			
Relationship:	Home Phone # *(with area code)*	Other Phone # *(with area code)*	
Mailing Address:	City:	State:	Zip Code:

❑ *Same as above Mailing Address* BILLING ADDRESS

Billing Address:	City:	State:	Zip Code:

❑ Same as Patient RESPONSIBLE PARTY INFORMATION

Print full legal name: last first middle	Relationship to Patient:	Social Security #:	
Mailing Address:	City:	State:	Zip Code:
Home Phone # *(with area code)*	Cellular/Other Phone # *(with area code)*	Date of Birth: *Month/Day/Year*	

INSURANCE/PAYMENT INFORMATION – See Insurance Form

How did you hear about us?

❑ Friend/Family ❑ Ad/Direct Mail ❑ Internet ❑ Phone Book ❑ Other _____

❑ Referring Dr.: _____ Glaser Patient:_____

(REFERRING PATIENT WILL EARN REFERRAL REWARD)

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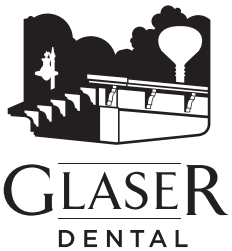

Please sign and bring to appointment

Dental Insurance Information

This information needs to be complete in order for us to provide the level of service you deserve

Patient Name: _____

Patient address:_____

City:_____State:_____Zip:_____

Patient's Date of Birth: _____ Sex: _____

Patient SS#: _____

Relation of patient to subscriber_____

Insurance Subscriber Name: _____

Subscriber SS# _____

Subscriber Date of Birth (dd/mm/yy): _____

Subscriber Address (if different from patient): _____

City:_____State:_____Zip:_____

Subscriber Employer (Company) Name: _____

Company address:_____

City:_____State:_____Zip:_____

Insurance Company Name: _____

SPECIAL (employee) ID #: _____

Group #: _____

Insurance Address (as listed on back of card):_____

Insurance CO. phone #:_____ _____

**Please list any secondary dental insurance you want your claims sent to.
**SS# is required to process insurance claims through our E-filing system
** In addition to this form you will be required to provide a current copy of your dental insurance card at your visit.

Please remember, we are only as good as the information you provide to us. If you have any changes to your contact information or your insurance information we need to be made aware of it before your appointment. It is our policy to submit the insurance claims to the company listed and the policy # outlined on this form. You are responsible for paying any co-pay, deductibles, and or rejected claims. We can not guarantee coverage for any procedure without a written pre-authorization from your insurance company

Patient Signature: _____ Date:_____

Print Patient Name: _____

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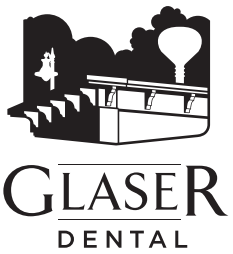

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Dental Insurance Information

For your convenience, we are an in-network provider for numerous PPO's, and as an added service our office will file your insurance claims. In order to submit your claim, we must have a current copy of your insurance card on file. If you fail to make us aware of changes to your insurance carrier at the time of your visit, the responsibility for payment for the office visit and subsequent reimbursement from your new insurance carrier will be yours.

All outstanding balances and co-pays will need to be paid or financing plans will have to be made with Debbie, before you can see the doctor at each office visit.

Please note that there are certain services and items that may not be reimbursed by your insurance carrier, but are the responsibility of the patient to pay.

Typical items the patient will be expected to pay include:

- Office visit co-pays
- Co-insurance payments for visits (example: 80%/20% insurance plans)
- All office visits prior to the unmet portion of the yearly deductible
- Office visits prior to insurance coverage or after coverage termination
- Any non-insurance covered service

Not all PPO's and insurance policies provide the same coverage. We strongly recommend that you contact your insurer prior to your visit to make sure that you know what procedures will be covered and at what percentage. If you do not have a copy of your current insurance card, most HR managers (if you have insurance through your employer) will help you obtain one.

Patient Signature: _____ Date:_____