



**PERSONAL INFORMATION**

NAME:

ADDRESS:

CITY:  STATE:  ZIP CODE:

HOME TELEPHONE:  OFFICE TELEPHONE:

CELLULAR TELEPHONE:  FAX:

EMAIL ADDRESS:

DATE OF BIRTH:  SOCIAL SECURITY NUMBER:

**PREFERENCES**

**How would you like us to remind you about your appointments?**

- Via Telephone (please note the best number)
- Via Fax
- Via Email

**What are your appointment preferences?**

- Day of the Week:
- Morning
- Afternoon
- After 5:00 p.m.

**Please list/check which accommodations you prefer:**

Your choice of Music:  Your choice of DVD:

Your choice of Cable TV Channel:  Your choice of beverage:

- Massage pad of chair
- Paraffin Gloves



*We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our "Financial Policy" is important to our professional relationship. Please ask if you have any questions about our fees, "Financial Policy," or your responsibility.*

**\*\*ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DOCTOR**

**\*\* FULL PAYMENT IS DUE AT TIME OF SERVICE**

**\*\*WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND AMERICAN EXPRESS**

**\*\*THIRD-PARTY FINANCING OPTIONS ARE AVAILABLE**

**\*\*RETURNED CHECKS ARE SUBJECT TO A SERVICE CHARGE AND CANNOT BE REDEPOSITED**

**\*\*CHARGES WILL BE MADE FOR BROKEN APPOINTMENTS THAT ARE CANCELLED WITHOUT ONE FULL BUSINESS DAY'S NOTICE**

#### **INSURANCE**

*If you have dental insurance we will help you receive maximum allowable benefits. We will help you complete claim forms so that you can be reimbursed by your insurance company to the extent of your coverage. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.*

*THE PATIENT IS FULLY RESPONSIBLE FOR THE ACCOUNT. If you have any questions about the above information or are uncertain regarding insurance information, PLEASE do not hesitate to ask. WE ARE HERE TO HELP.*



**PRIVACY**

*I hereby authorize Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of my dental needs. I also authorize Doctor to publish the aforementioned materials for proprietary Glassman Dental Care marketing purposes, provided I give my consent prior to publication. I also authorize Doctor to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.*

*I further authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or consulting professionals. The release to the insurance company is solely for the purpose of facilitating the filling and reimbursement of insurance benefits for which I am entitled.*

*"I understand and agree that I am responsible for my account and agree to pay at the time of services rendered. I have read and agree to all the information on this sheet."*

NAME (please print)  DATE

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT OR GUARDIAN (of minor) \_\_\_\_\_ DATE \_\_\_\_\_