CENTER FOR COSMETIC DENTISTRY

324 Greece Ridge Center Dr., Rochester, NY 14626
Dr. Paul I. Sussman <> 227-SMILE (6453) <> Dr. Meredith A. Pogal

PATIENT INFORMATION========== CONFIDENTIAL ==========

WELCOME!

Date: _____

How did you select our office?

Internet ____ Location ____ Insurance ____ Radio FM AM TV _____ Patient (who?) _____Other_____

Name: _____
first middle last

Address: _____
street city state zip

Date of Birth: _____ **Social Security** #: _____ **E-Mail** _____

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

TELEPHONE

Home: _____ Work: _____ Cell: _____ Other: _____

When/Where is the best time to reach you? _____

Emergency Contact name/number: _____

Patient's or Parent's Employer: _____ Occupation: _____

Business Address: _____
street city state zip

Spouse or Parent's Name: _____ Employer: _____ Work#: _____

If patient is a student, name of school/college: _____City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY==========

Name of person responsible for this account: _____ Relationship: _____

Address: _____
Street city state zip

Home Phone: _____ Soc. Sec. #: _____ Birth date: _____

Drivers license #: _____ Employer: _____ Work Phone #: _____

Is this person currently a patient in our office? ☐ Yes ☐ No

FINANCES==========

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option that you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

□ **Cash** □ **Check** □ **Credit Card** □ **Outside Financing**

Card # _____ **Exp. Date** _____ **Signature** _____

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Authorization, release, and agreement to pay for services rendered

I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers. I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I am responsible for payment regardless of insurance company's arbitrary determination of reasonable and customary rates. I understand that payment is expected when services are rendered unless other arrangements are made in advance. A monthly service charge of 1.33% per month will be added on all accounts not paid within 30 days. In the event that Center For Cosmetic Dentistry pursues civil remedies against me for collection of financial obligations, I hereby agree to be responsible for collection and/ or attorney fees and disbursements incurred by Center For Cosmetic Dentistry. Unless canceled at least 48 hours in advance, a $75.00 fee will be incurred for missed appointments. Please help us to serve you better by keeping scheduled appointments.

Signature_____**Date**_____

INSURANCE INFORMATION==========

Name of insured: _____ Relationship _____

Birth date: _____ Social Security #: _____ Date Employed: _____

Employer: _____ Work Phone: _____

Address of Employer: _____
Street city state zip

Insurance Company: _____ Group #: _____

Ins. co. address: _____ Ins. co. phone#: _____

How much is your deductible? _____ Maximum annual benefit? _____

Do you have secondary insurance? □ **Yes** □ **No** **If yes, complete the following**

Name of insured: _____ Relationship _____

Birth date: _____ Social Security #: _____ Date Employed: _____

Employer: _____ Work Phone: _____

Address of Employer: _____
Street city state zip

Insurance Company: _____ Group #: _____

Ins. co. address: _____ Ins. co. phone#: _____

How much is your deductible? _____ Maximum annual benefit? _____

mailto:appointments@22-smile.com