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?

Yellow pages ____ 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** __________________________

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 payors. 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 2% 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 cancelled 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? ________________