Center for Smile Enhancement . Michael S. Sudit, D.D.S. LLC
10500 Wayzata Blvd. Minnetonka, MN 55305
(952) 593-9310

We are pleased to welcome you to the Center for Smile Enhancement!

Patient and Account Information

Patient Information

Driver's License # _____

Name _____ Home phone _____
Last First Middle initial

Address _____
Street Address City State Zip

Male___ Female ___ Age_____ Birthdate _____ SS # _____

Employer _____Occupation _____Work Phone _____

E-mail _____Cell Phone_____

Marital Status _____

Spouse's Name _____ Birthdate _____

Employer _____ Work Phone _____

Whom may we thank for referring you to our office? _____

Who should we notify in case of emergency?

Name: _____Relationship: _____

Phone: (h)_____ (w)_____(c)_____

Account Information

*After confirmation of dental insurance benefits, we will be happy to file your insurance claims for you. We require that the patient's estimated portion be paid at the time services are rendered. Please provide your insurance card with your completed information.

Who is responsible for this account? (if different from above)

Name _____ Insured: Yes ___ No ___

Relationship to patient _____Birthdate _____SS# _____

Address (if different from patient) _____
Street Address

_____ Home phone _____
City State Zip

Employer _____ Occupation _____

Business Address _____ Work Phone _____

Insurance Information

Subscriber's Name _____

Insurance Company _____Phone_____

Claim Mailing Address_____
Street City State Zip

Group # _____ Subscriber ID # _____

Credit Card Information: MC VISA AMEX

Card number:_____ Exp. Date:_____ Security Code:_____

Name as it appears on card: _____

Signature (for authorization): _____

AUTHORIZATION

I agree to be fully responsible for the total payment of dental services provided on my behalf of my dependents, due and payable at the time services are rendered unless prior arrangements have been made. I understand I am also responsible for payment of applicable late fee finance charges at a rate of 1.75% monthly in addition to any fees associated with collection activity on my account.

I understand that any insurance quote is an estimate only and not a guarantee of payment. I am responsible for all charges whether or not paid by insurance. I authorize my insurance company to pay directly to the dentist, benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits. I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge.

Signature _____ **Date** _____

_____**YES, I WOULD LIKE TO BE NOTIFIED BY E-MAIL FOR APPOINTMENT CONFIRMATION AND SPECIALS**