



**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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home phone \_\_\_\_\_

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**