Advanced Aesthetic Smiles of NY

Dr. Christine Skordeles
45 West 54th street 1c
New York, New York 10019

PATIENT REGISTRATION INFORMATION

Date_____ Soc. Sec. #_____Date of Birth _____(month/day/year)

Name:_____

Address:_____
City:_____State:_____ZipCode:_____

Home Phone:_____Cell Phone_____

Gender: Male Female E-mail Address:_____

Marital Status: Single Significant other Married Divorced/Separated Widowed

Is the patient a minor? Yes No If YES name of guardian_____

Employer:_____Business Phone:_____

BusinessAddress :_____Occupation:_____

City:_____State_____ZipCode:_____

Who referred you to our office_____

In case of emergency, whom should we contact?
_____ Phone:_____

PRIMARY INSURANCE

ResponsibleParty:_____

Relationship to Patient:_____Date of Birth:____/___/___Soc. Sec. #_____
Address:_____

City:_____State:_____ Zip Code:_____

Responsible Party Employer:_____Business Phone:_____
BusinessAddress:_____Occupation:_____

City:_____State:_____ ZipCode:_____

Insurance
Company:_____InsuranceAddress:_____

Subscriber I.D. # _____Group #:_____

ADDITIONAL INSURANCE (IF APPLICABLE)

ResponsibleParty:_____
Last Name First Name MI

Relationship to Patient:_____Date of Birth:___/____/____Soc. Sec. #____-_____-___
Address:_____ APT.#_____
City:_____State:_____ZipCode:_____
Responsible Party Employer:_____

Business Phone:_____-_____-_____

BusinessAddress:_____

Occupation:_____
City:_____State:_____ Zip Code:_____

InsuranceCompany:_____

Insurance Company Address:_____

Subscriber I.D. #_____Group #_____

ASSIGNMENT AND RELEASE

I hearby authorize payment directly to Dr. Christine Skordeles, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party:_____

Date:_____/_____/_____