Mitchell V. Sabbagh DMD, PC www.AestheticDentistryOfNewYork.com

PATIENT HEALTH INFORMATION

Our goal is to help you achieve and maintain optimum oral health for a lifetime. So that we may best serve you, please complete these forms before your initial appointment with our office. We appreciate the confidence you've placed in us by selecting our team of dental professionals. We will continue to warrant that trust as we serve your dental needs.

Personal Profile Date ____/____/_______

First Name ______________________________ (MI) _____ Last Name ______________________

I like to be called ______________________ □ Female □ Male Driver's License _____________

Date of Birth ____/____/_________ Age _____ Social Security Number _____ - _____ - _________

Home Phone (____) _____ - _________ Work Phone (____) _____ - _________ Ext _____________

Cell Phone (____) _____ - _________ Fax (____) _____ - _________

Street Address __________________________ City ________________ State _____ Zip __________

E-mail ____

What number would you like us to call you on regarding your appointments? _______________

Name of Employer ___________________________ Occupation ___________________________

Who may we thank for referring you to our practice? _______________________________

Previous dentists name _____________________________________ Phone (____) _____ - ______

Last seen by previous dentist ____/____/____ Treatment rendered _________________________

Would you like us to contact your previous dentist for applicable records? □ No □ Yes

Account Information

Responsible Party's: Self/Other Name ____

Street Address __________________________ City ________________ State _____ Zip __________

Home Phone (____) _____ - _________ Work Phone (____) _____ - _________ Ext _____________

Social Security # ______ - _____ - _________ DOB____/____/_____ Driver's License _____________

Insurance Information - Primary

Insurance Company's Name ____

Street Address __________________________ City ________________ State _____ Zip __________

Insured's First Name _____________________ (MI) ____ Last Name ___________________________

Social Security # ______ - _____ - _________ DOB____/____/_____ Driver's License _____________

Insurance Information - Secondary

Insurance Company's Name ____

Street Address __________________________ City ________________ State _____ Zip __________

Insured's First Name _____________________ (MI) ____ Last Name ___________________________

Social Security # ______ - _____ - _________ DOB____/____/_____ Driver's License _____________

Who should we contact in the unlikely event of an emergency?

Name ___________________________________ Relationship to patient ____________________

Home Phone (____) _____ - _________ Work Phone (____) _____ - _________ Ext _____________

E-mail _____________________________________ Cell Phone (optional) (____) _____ - _________

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