AESTHETIC DENTISTRY OF NEW YORK

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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