



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
Street Address City State Zip
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 Pager
Pager E-mail
What number would you like us to call you on regarding your appointments?
Name of Employer Occupation
Street Address City State Zip

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 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

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)