



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 (___) ___ - ___ 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 _____

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) (___) ___ - ___