David A. Sabourin, D.D.S., APC

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

Patient's legal name: First/MI/Last

____

Prefer to be called: __________________ **Social Security#:**__________________ **DOB:** ___________

Sex: ___ **E-Mail:** ___________________________________ **Cell phone**: ___________________________

Home phone: _____________ Work phone: ______________ Marital Status: ___S ___M ___W ___D ___Under Age 18

Address: Street/Apt #/City/State/Zip

____

Patient's/Guardian's Employer: ________________________________ Occupation: ________________________

Work address: Street/Suite #/City/State/Zip

____

Spouse's Name: ___________________________________ Employer: _____________________________

Work address: _______________________ Work phone: _________________ Occupation: ______________________

Whom may we thank for referring you? ____

Person we may contact in case of an emergency: ____

Their telephone: ____________________________ Relationship to you: _________________________________

CONFIDENTIAL COMMUNICATION: *Please check the methods below you prefer to be contacted*

____**Cell** ____**E-mail** ___ Work ___Home ___ Voice Mail cell ___VM work ___ VM home

APPOINTMENT CONFIRMATIONS: As a courtesy, we typically make contact by e-mail or cell phone.

Please ***circle*** either: **YES**, it is a helpful reminder or **NO**, it is unnecessary.

I authorize the dentist to release any information for an insurance claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy. I consent to making of videotapes, photographs and x-rays before, during and after treatment; and to use the same by the doctor in scientific papers, demonstrations and/or presentations. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature of patient/agent____ Date____________________

DENTAL INSURANCE INFORMATION: *Please provide us with your insurance card*

Primary Dental Carrier: ___________________________________ Phone #:___________________________________

Billing address: ____ Group number: _______________________

Subscriber/Employee name: _____________________________ Employer: _________________________________

Subscriber **SSN**: ______________________ **Date of birth**: ____________________ **ID #:** ____________________________

Secondary Dental Carrier: ___________________________________ Phone #: __________________________________

Billing address: ____ Group number: _______________________

Subscriber/Employee name: _______________________________ Employer: _______________________________

Subscriber **SSN**: ______________________ **Date of birth**: ____________________ **ID #:** ____________________________