

*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 #**: \_\_\_\_\_