Sabre Springs Dentistry
Mina Habibian, D.M.D., Ph.D.
Family & Cosmetic Dentistry

Welcome to our practice

(If you do not see the fill out fields (sky blue background) please click on "Highlight Fields" button at the top right hand corner of this page).

Today's Date **Record number (office use only)**

Patient information

Last name First name Middle name

SSN DOB Sex: M. F. Marital Status S. M. Wid.

Street address City State Zip code

Home phone # Work phone # Cell # Email:

Occupation Employer or school (if student) Employer phone #

Best method to contact the patient Cell phone Home phone Work phone Email

Whom we may thank for referring you to us?

Insurance information

Please show your insurance card to the receptionist

Is this patient covered by insurance Yes No Please indicate the primary insurance

Subscriber's name SSN DOB ID# Policy#

Patient relationship to the subscriber Self Spouse Child Other

Please indicate the secondary insurance (if applicable)

Subscriber's name SSN DOB ID# Policy#

Patient relationship to the subscriber Self Spouse Child Other

Person responsible for the bill Occupation Relationship to the patient Self

Spouse parent Other Phone# Address

Is this person a patient here Yes No

In case of emergency

Name of a local friend or relative to notify in case of emergency Relationship to patient

Phone# Address

The above information is true to the best of my knowledge. I assign all the insurance benefits if any to Sabre Springs Dentistry and authorize the use of my signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I also authorize Dr Habibian or insurance company to release any information required to process my claims. I undersigned hereby authorize dentist to take radiograph, study model, photograph, or any other diagnostics aids deemed appropriate to make**thorough** diagnosis of the patients dental need. I authorize dentist to use any photo taken for lecturing, publishing or education purposes.

Patient/Guardian signature _____ **Date** _____