WELCOME to the practice of *Embassy Row Dental.* We look forward to working with you in maintaining your dental health. We offer exceptional dentistry for exceptional smiles.

Please fill in the following 3 pages for your Patient Information and Health History and bring them with you on your first visit.

PATIENT INFORMATION

Name_____ Soc.Sec.#_____

Address_____

City _____ State _____ Zip _____ Home Phone_____

Cell Phone _____ Email _____

Sex _____ Birthday _____

Patient Employed by _____Occupation_____

Business Address _____Business Phone _____

Business Email _____

Whom may we thank for referring you or which web site? _____

Notify in case of emergency _____ Phone _____

INSURANCE INFORMATION

Insurance Company _____ Group # _____

Subscriber # _____ Payer ID # (if applicable)_____

Address of Insurance Company _____

Phone # of Insurance Co. _____ Type of Policy (PPO or other)_____

I authorize the insurance company to pay to the dentist all insurance benefits and authorize the use of this signature on all insurance submissions. I authorize the release of information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

COMMENTS OR QUESTIONS