**Urmi Amin, DDS MS**

**10 El Camino Real, Suite 102**

**San Carlos, CA 94070**

**Phone: (650) 596-8045. Fax: (650) 596-8074**

**SIGN IN FORM**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH CHANGES? YES\_\_\_\_ NO \_\_\_**

**INSURANCE CHANGES? YES \_\_\_\_ NO \_\_\_**

**EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BEST CONTACT NUMBER : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have reviewed my health history and confirm that it accurately states past and present conditions.

I also understand that my dental insurance or payer of my dental benefits may pay less than the actual bill for service. By signing this, I am financially responsible for payments in full of all accounts.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_