Prestige DENTAL CARE WEST

PATIENT INFORMATION

NAME: Last _____First _____ DOB_____

Cell Phone _____ Home Phone _____

Emergency Contact Name: _____ Phone _____

How did you hear about us today? _____

Email:_____ When was your last Dental visit? _____

I would like to receive appointment reminders via email or text message.

E-Mail: _____ TEXT Number: _____

RESPONSIBLE PARTY or INSURANCE HOLDER

Name of Main Subscriber: _____ DOB _____

INS Company: _____ Phone _____

Group#_____ SS# _____

Subscriber ID# _____ Employer: _____

Patient/ Parents/ Guardian: I hereby authorize payment directly to Prestige Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Prestige Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information above

Signature of Patient/Parent/Guardian_____ Date_____