three sixty
DENTISTRY
BRIAN EDWARDS, DDS

Patient Information

Last Name	First Name		MIddle Initial
Preferred Name	Referred By		
Address	City	State	Zip
Cell Phone	Home Phone	Birthdate / /	
Email	Gender M ☐ F ☐		
Occupation	Single ☐ Married ☐ Divorced ☐ Separated ☐		

Emergency Contact

Last Name	First Name
Cell Phone	Home Phone

Financial

Who is financially responsible? Please circle:	Self (same information as above) ◯	Other (please fill out below) ◯	
Last Name	First Name		Middle Initial
Address	City	State	Zip
Cell Phone	Home Phone		

I agree to be responsible for any charges on this account

Financial Party's Signature _____

Primary Dental Insurance

Ins. Co. Name	Ins. Co. Phone Number
Employer	Social Security Number
ID Number	Group Number
Subscriber's Name	Relationship to Patient

Secondary Dental Insurance

Ins. Co. Name	Ins. Co. Phone Number
Employer	Social Security Number
ID Number	Group Number
Subscriber's Name	Relationship to Patient

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Medical History

1. Please check all that apply:

☐ *Medication Allergy	☐ *No Epinephrine*	☐ *Other	☐ *Pre-Med Antibiotics
☐ Acid Reflux/ GERD	☐ ADD or ADHD	☐ Anemia / Low Iron	☐ Arthritis/Rheumatism
☐ Artificial Joint	☐ Asthma/BreathingProb	☐ Bleeding Problems	☐ Blood Disease
☐ Cancer	☐ Chemotherapy Tx	☐ Chest Pain / Angina	☐ Congen. Heart Defect
☐ Cortisone / Steroids	☐ Dementia	☐ Dental/Needle Phobic	☐ Depression
☐ Diabetes	☐ Dizziness/Fainting	☐ Down Syndrome	☐ Drink/Eat Grapefruit
☐ Dry Mouth	☐ Hearing Loss	☐ Heart Attack	☐ Heart Murmur
☐ Heart Valve Replaced	☐ HeartDisease/Surgery	☐ Hepatitis	☐ High Anxiety/ Nerves
☐ High Blood Pressure	☐ High Cholesterol	☐ HIV or AIDS	☐ Hx Alcohol/Drug Use
☐ Iodine/Shellfish	☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease
☐ Low Blood Pressure	☐ Mental/PsychDisorder	☐ Mitral ValveProlapse	☐ Multiple Sclerosis
☐ No Fluoride	☐ Osteoporosis	☐ Pacemaker	☐ Penicillin Allergy
☐ Pregnant (Currently)	☐ Radiation Treatment	☐ Respiratory Problems	☐ Seizures or Epilepsy
☐ Sinus Problems	☐ Snore or Sleep Apnea	☐ Stomach/ GI Problems	☐ Stroke
☐ Sulfa Allergy	☐ Taking Birth Control	☐ Teeth Grind/Clench	☐ Thyroid Disease
☐ TMJ Click/Pop/Pain	☐ Tobacco Products	☐ Tuberculosis	☐ Viral / Cold Sores

2. Please list all MEDICATIONS that you are taking and WHY you are taking them:

3. Please list all ALLERGIES:

4. Please List all HOSPITALIZATIONS:

5. Are you currently being treated by your physician for something? Yes ☐ No ☐

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Dental History

1) Have you ever taken antibiotics prior to dental treatment? Yes ☐ No ☐

2) How often do you get your teeth cleaned?

_____

3) When was your last dental visit?

_____

4) Have you had a "deep cleaning" or "scale and root planing" ? Yes ☐ No ☐

5) Is there something you would change about your smile? Yes ☐ No ☐

7) Have you had trouble getting numb for past dental procedures? Yes ☐ No ☐

8) Do you have a dry mouth? Yes ☐ No ☐

9) Do you avoid certain foods/drinks because they hurt your teeth? Yes ☐ No ☐

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3 Year Warranty Guarantee:

Due to the confidence in our ability and desire to provide you with the best possible dental care you can receive, our office will provide you with the following guarantee:

1st year of service (from time of placement): 100% Coverage (you pay nothing)
2nd year of service: 70% Coverage (you pay 30%)
3rd year of Service: 60% (you pay 40%)
4th year of service: 50% (you pay 50%)
5th year of service: 40% coverage (you pay 60%)
6th year of service: 0% (you are fully responsible)

Please note that whitening, periodontal therapy, bondings on the edges of front teeth, and TMJ treatment are not covered by this guarantee.

Financial Policy:

1. **5% savings** if you pay in full at time of service (cash, check, Visa, Mastercard, American Express, Apple Pay, flex account, or health spending account)

2. Interest free monthly payment plans through third party financing

3. Crown, bridge, implant, or any other procedures with a lab component have the option to pay half on the initial appointment and half on the delivery appointment

4. If you choose to wait for an insurance payment, you are still responsible for the estimated patient portion at time of service. If we are unable to estimate your portion, we ask that you leave your credit card information on file. Once the amount is determined, we will call to ask your permission to run the card on file. We will take care of all the insurance billing for you. All insurance companies, except Delta, will allow our dental office to receive the insurance check.

Cancellation Policy:

We do not double book appointments to give you attentive service and reduce waiting times. We will do our best to be on time and we ask for the same in return.

We require a **48 hour notice** for any appointment change. Failure to do so may result in a broken appointment fee. For some patients it works best to pay the cancellation fee and for other patients that have an unpredictable schedule, prefer that we call on short notice when an appointment becomes available (instead of reserving ahead and risking the cancellation fee).

Referral Rewards Program:

The highest compliment you could give our office is by referring a friend or family member. In appreciation for each referral, you may select between movie tickets, Starbucks gift card, or flowers, plus you will be entered into a drawing for a larger prize.

Privacy Practices and Dental Material Fact Sheets:

Our Notice of Privacy Practices provides information about how we may use and disclose protected information about you. The Dental Materials Fact Sheet summarizes information on the most frequently used restorative dental materials. You may obtain a copy of the Notice of Privcay Practices or Dental Materials Fact Sheet by visiting out website https://www.threesixtydentistry.com/new-patient-info/ or there is a physical copy for your convenience at our front desk.

I have read this page and agree to all of the information above:

Signature:_____ **Date**: _____