Dental 360

Family & Cosmetic Dentistry

Patient Information

Please Print

First: ______________________________ MI: ______ Last: ______________________________________ Jr / Sr

Single / Married / Widow Sex: M / F

Date of Birth: _____________________________

Patient SSN: ______________________________ Driver's License #: _______________________ State: _______

Mailing Address:

Street: __________________________________ City: _______________________ State: _______ Zip: __________

Email Address: ____

Home Phone: ________________________ Work: ________________________ Cell: _______________________

Would you like to be contacted by text? Y / N

Patient Employer: ____ Occupation: _____________________________

Physical Address *(if not the same):*

Street: __________________________________ City: _______________________ State: _______ Zip: __________

Emergency Contact: ______________________________________ Phone: __________________________________

Insurance Information

Do you have Dental Insurance? (circle) Yes / No

Subscriber Name, if not self: _____________________________________ Subscriber SSN: ___________________

Subscriber Date of Birth: ________________________ Relationship to Subscriber : self / spouse / child / other

Subscriber Employer: ____ Employer Phone: _______________________

Insurance Company: ____

Insurance Group Number: ______________________________ Insurance Phone: _____________________________

Please present your insurance card to the receptionist

Who may we thank for referring you? ____

Dental Visit—Reason for today's visit: ____

What areas of your mouth are giving you discomfort, or you would like to improve? ___________________________

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I attest to the accuracy of the information on this page and give consent to the diagnostic procedures and treatment by the dentist for necessary and proper dental care. I consent to the disclosure of my records to carry out treatment, obtain payment, confirm appointments, and other functions relative to treatment or payment. I am aware of the office HIPPA Privacy Policy, I have been offered a copy of his policy, have signed the office copy, and have access to the policy through the dental office upon request. By signing this form, I am also agreeing to be responsible for payment of services.

Patient or Guardian's Signature: ____ Date: _____________