ACQUAINTANCE FORM

I was referred to you by _____ Date _____

Name _____ I prefer to be called _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Business Telephone _____

Other Telephone _____ E-Mail Address _____

Birth Date _____-_____-_____ Age _____ Sex _____ SS# _____

Marital Status _____ Spouse _____ Do you have any Children? _____ How Many? _____

Employer _____ Occupation _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Home Telephone _____ Business Telephone _____

Birth date _____-_____-_____ Sex _____ SS# _____

Employer _____ Occupation _____

DENTAL INSURANCE

Primary Insurance Company _____

Employee _____ SS# _____

Employer _____ Group Number _____

Secondary Insurance Company _____

Employee _____ SS# _____

Employer _____ Group Number _____

CONSENT: I authorize Armendariz Family Dentistry to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by him to make a diagnosis of my (my child's) dental needs. I understand that consultation with other health professionals may be required to assist with diagnosis of my (my child's) dental conditions. I authorize release of supporting records and information to and from this office for this purpose. I also understand that the use of anesthetic agents embodies a certain risk.

_____ Date _____

Signature of Patient, Parent or Guardian

In case of emergency, please contact

Name _____ Telephone _____

GENERAL HEALTH HISTORY

Are you in good health? If no, explain…… YES NO

Are you under a physician's care now?…… YES NO
If yes, please explain ……
Name of Physician …….. Phone ……..

Are you now taking any drugs or medications? …… YES NO
If yes, please list ……

Do you currently or have you ever taken any osteoporosis medications in the past? …… YES NO
If yes, please list ……

Are you sensitive or allergic to any drugs? …… YES NO
If yes, please list……..

Have you been hospitalized in the past two years? …… YES NO
If yes, please explain ……..

Do you now have or have you had any of the following?

A.I.D.S. **OR** H.I.V….	YES	NO	Herpes	YES	NO
Allergies	YES	NO	Hepatitis	YES	NO
Anemia **OR** Blood Disease	YES	NO	High Blood Pressure	YES	NO
Asthma **OR** Hay Fever	YES	NO	Kidney Disease	YES	NO
Artificial Joint or Valve	YES	NO	Liver Disease	YES	NO
Cancer	YES	NO	Radiation Treatment	YES	NO
Diabetes	YES	NO	Rheumatic Fever	YES	NO
Epilepsy	YES	NO	Rheumatism or Arthritis	YES	NO
Excessive Bleeding	YES	NO	Stroke	YES	NO
Fainting Spells or Seizures	YES	NO	Stomach Ulcers	YES	NO
Heart Disease	YES	NO	Tuberculosis	YES	NO
Heart Murmur	YES	NO	Venereal Disease	YES	NO

Do you have any disease, condition, or problem not listed above? …….. YES NO
If yes, please explain……..
Have you ever been told to pre-medicate with antibiotics before your dental treatment? …… YES NO
WOMEN: Are you pregnant? If yes, due date …….. YES NO
Are you taking birth control pills? …… YES NO

DENTAL HISTORY

What is the reason for your visit? ……
Date of your last dental treatment …… Last Cleaning ……
How often do you brush your teeth? ……. Floss? ……...
Do your gums bleed, or feel tender or irritated? …… YES NO
Are your teeth sensitive to hot, cold, sweets or pressure? ……. YES NO
Are you aware of grinding or clenching your teeth? ……. YES NO
Do you have headaches, earaches or neck pains? …….. YES NO
Are you apprehensive about dental treatment? …….. YES NO
Have you ever had a bad reaction to dental anesthetic? ……. YES NO
Are you unhappy with the appearance of your teeth? …… YES NO
Does food catch between your teeth? ……. YES NO
Have you ever worn braces on your teeth? ……. YES NO
Do you wear dentures? …… YES NO
Are you unhappy with your dentures? …… YES NO
Would you like us to help you learn the proper methods of home care, so you can stop dental problems before they start? ……. YES NO

The above information is true and I will notify you of any changes.
Signature _____ Date _____

Armendariz Family Dentistry
18555 N. 79TH AVE. SUITE B-104
GLENDALE, AZ 85308
(623)334-2400

Financial Agreement – Please read the following information completely.

If you do not have dental insurance, the total fee is your responsibility. Payment is expected at the time of service. If you are unable to pay for services in full, please feel free to speak with Sherrie prior to having your treatment started to review payment options we have available. For your convenience, we accept cash, checks, VISA, Mastercard, Care Credit and American Express.

As a courtesy to our patients with dental insurance, we are happy to assist in filing insurance claims for you. ***Please understand that dental benefits paid by your insurance carrier are determined by a contract between your employer and the insurance company and we can only provide an estimate of benefits. Any unpaid balance is your responsibility.*** We only provide composite (tooth-colored) fillings and some insurance companies may apply an alternate benefit for amalgam (silver) fillings. I authorize the release of any required information to my insurance company and authorize payment directly to Armendariz Family Dentistry for any claims submitted on my behalf.

If you are unable to keep your appointment, we request at least TWO BUSINESS DAYS notice so we may give this time to another patient. Failure to do so may result in a missed appointment charge of $50.00. Please keep in mind, our days of business are Monday through Thursday.

I (we) agree to pay court costs, attorney fees and up to 50% of the collection fee on any outstanding balances that require placement with an outside agency.

Patient_____

Guardian _____

Date_____