SONORAN VALLEY DENTAL CENTER 3719 W. Anthem Way, Suite 101 • Anthem, AZ 85086 • (623)233-1033

PATIENT AQUAINTANCE FORM

Patient Name: ______________________________ Home Phone: ______________
Address: STREET ______________________________ Mobile Phone: ______________
CITY ______________ STATE ________ ZIP ________ Work Phone: ______________
Sex: ___ Marital Status: ____ Birthday: __________ Social Security: __________ Employer: ______________
Patient Email Address: ______________________________ Preferred Contact Method: ________

Emergency Contact: ______________ Relationship: ________ Primary Phone: ______________

Dental Insurance: ______________________________ Insurance Phone: ______________
Policyholder Name: ______________ Employer Name: ________ Group Number: ______________
Relationship to Patient: ________ Policyholder Birthday: ______________ SSN/Member ID: ______________

How did you hear about us? ☐Referral______________ ☐Google ☐Facebook ☐Yelp ☐NextDoor App
☐Drive By ☐Insurance Company ☐Word of Mouth ☐Other: ______________

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING CONDITIONS?

☐HIV/AIDS diagnosis or exposure
☐Hepatitis
☐Liver Problems
☐Joint Replacement(s) Date and Type: ______________
☐Heart Murmur
☐Heart Ailments (vascular surgery, pacemaker)
☐Mitral Valve Prolapse
☐Depression
☐Rheumatic Fever
☐Stroke
☐Traumatic Brain Injury
☐High Blood Pressure
☐Currently on a blood thinner (Coumadin, Warfarin, Aspirin, etc.)
☐Excessive Bleeding
☐Take or have taken Fosamax or Boniva Duration: __________
☐Anemia
☐Tuberculosis
☐Ulcer
☐Colitis
☐Kidney Problems
☐Diabetes

☐Arthritis
☐Radiation Treatments
☐Blood Problems
☐Malignancies
☐Epilepsy
☐Nervous Disorders
☐Fainting or Dizziness
☐Venereal Disease
☐Asthma
☐Hay Fever
☐General Allergies
☐Sinus Problems
☐Pregnant How far along? ______________
☐Smoking Cigarette, Pipe, or Cigar How Long: __________
☐Teeth Sensitivity (Cold, Heat, Sweets, Pressure)
☐Clenching or Grinding
☐Gums Bleed Easily
☐Previous Periodontal Treatment
☐Previous Orthodontic Treatment
☐Unfavorable Dental Experience
☐**OTHER CONDITIONS:** ______________

ALLERGIC TO ANY DRUGS/ANESTHETICS/LATEX? Please list: ______________________________

CURRENT MEDICATIONS AND/OR SUPPLEMENTS:

____
____

Are you currently under the care of a physician? If so, why? ______________________________
Physician's Name: ______________________ Date of last physical exam? ______________
Chief Oral Complaint: ____
Dates of Last Dental Exam: __________ X-rays: ______________ Cleaning: ______________
Is there anything you would like to change about your smile? ______________________________

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

Signature: ______________________ Relationship to patient: ______________ Date: ______________

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sonoranvalleydental@gmail.com
facebook.com/sonoranvalleydental

Our goal is to provide all of our patients with superior dental care and customer service. We hope to build a relationship of trust through our quality of care and excellent level of communication. Please review our practice details below.

Office Hours:
Monday - Friday: 9:30AM - 5:00PM
Saturday by Appointment: 9:30AM – 3:00PM
Sunday: CLOSED

Emergency Contact Info: For a true dental emergency requiring same day treatment, please contact our office at 623-233-1033.

Methods of Payment: Cash, Check, Visa, Mastercard, American Express, Discover, Care Credit

Financing: Care Credit carecredit.com

Appointment Confirmations: We take our schedule very seriously as well as your time. We require confirmation for all dental appointments. We will begin reaching out to you a week prior to your appointment and ask that you confirm via phone call, text, or email.

Change of appointment: In the event we do not receive confirmation, we reserve the right to remove your appointment from the schedule. We require a minimum notice of 48 business hours to reschedule or cancel weekday appointments.

Weekday Appointments: There is a **$50 fee** for appointments changed under 48 business hours.

Saturday Appointments: There is a **$75 fee** if the appointment is not rescheduled or canceled by Wednesday at 11:00AM.

Insurance: Payment is ultimately the responsibility of the patient. As a courtesy our office will bill to PPO or Traditional Indemnity Plans. We are NOT an HMO or DMO contracted office. Our office obtains an estimate of benefits from your PPO or Traditional Indemnity Insurance Carrier. A Treatment and Estimate will be created for you. Estimates are never a guarantee of payment. After your insurance remits payment, a statement will be created and sent to you if there is a balance. Your payment within 10 days is appreciated.

If payment is not received within 90 days of services rendered, you may incur a $20.00 financial fee and your account may be forwarded to a Collections Agency. Any account referred to a Collections Agency forfeits any specials or discounts.

I acknowledge that I have read and understand the policies referenced above and have had all questions answered regarding these policies. I agree to the terms above.

Patient Name: ____

Signature: ____ Date: __________________

Relationship to Patient: ____________________________________

INFORMED CONSENT

I hereby give my consent to use local anesthetics, relaxants, anti-inflammatories, antibiotics, antihistamines, steroids, or pain medications if deemed necessary for the completion of any medical or dental treatment.

I hereby grant permission to take photographs of my mouth, head, and/or neck to be used, without revealing my identity, for the furthering of medical and dental knowledge and education, especially for the benefit of other patients and dental professionals.

I understand whenever a tooth is extracted, there is a possibility of infection, bone fracture, temporary paresthesia (numbness) of the lip, gum, tongue, and/or facial skin. It is possible, although rare, that the paresthesia (numbness) would be permanent.

I understand that root canal treatment is an attempt to retain a tooth that would otherwise require an extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth undergoing root canal treatment may undergo acute infection and require retreatment, surgery, or (rarely) extraction. Restoration with a crown or a ceramic onlay should always follow a root canal treatment to ensure a good long-term prognosis. Sometimes a post is also indicated.

I understand that preparation for crowns, bridges, fillings, and onlay/inlays may, on occasion, traumatize the pulp (nerve). If the pulp (nerve) is in a weakened condition, this may necessitate a root cancel treatment on the tooth in the future.

Women taking birth control pills should be aware that antibiotics, such as but not limited to: penicillin or erythromycin, could possibly counteract the effects of the pill and render it ineffective against preventing pregnancy.

I realize that any of the treatment the doctor proposes can be performed by a specialist. I will tell the doctor or his staff I desire that a specialist perform the treatment.

Finally, I realize that any costs incurred during treatment are my responsibility. I realize that my insurance may help pay part f my treatment costs and that any estimates of insurance benefits quoted to me are *only* estimates. I will ultimately be responsible for any balance on my account left unpaid by the insurance company.

I understand that if I fail to give a 48-hour notice (dependent up the type of appointment) to cancel a scheduled/reserved appointment time block, that I will be charged a fee up to the amount of the schedule appointment procedure. I also understand that any x-rays taken are the property of the dentist and a fee may be charged for duplications or transfer of said x-rays.

I certify I have not taken any mood- or mind-altering drugs prior to signing this form.

Patient Name: ____

Signature: ____ Date: _____________________________

Relationship to Patient: ____

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Acknowledgement Of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.

Obtain payment from third-party payers for my health care services.

Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact his office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize Sonoran Valley Dental Center to release any and all information as it pertains to my records, account, insurance and appointments to the following people (examples: significant other or family members):

Name: ______________________________________ Relationship: ____

Name: ______________________________________ Relationship: ____

Name: ______________________________________ Relationship: ____

Patient Name: _______________________________________

Signature: ____ Date:_______________________

Relationship to Patient: ____

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SOCIAL MEDIA CONSENT AND RELEASE FORM

I hereby authorize Sonoran Valley Dental Center to use my photo and/or information related to my experiences with Dr. Gomez and/or Sonoran Valley Dental Center. I understand this information may be used in publications, including electronic publications, audiovisual presentations, promotional literature, advertising, community presentations, letters to area legislators and media and/or other similar ways. Sonoran Valley Dental Center will disclose to me or my legal representative, where appropriate, the specific information and/or photo to be used prior to release in the social media.

My consent is freely given as a public service to Sonoran Valley Dental Center/Dr. Gomez, without expecting payment. I release Dr. Gomez and Sonoran Valley Dental Center and their respective employees, officers and agents from any and all liability which may arise from the use of such news media stories, promotional materials, written articles, videotape and/or photographs.

I prefer that:

- ☐ My complete name be used
- ☐ My first name only be used
- ☐ No name be used
- ☐ I DO NOT consent to Social Media

I understand that I can revoke this release any time in writing and that the use of any of my photos or other information authorized by this release will immediately cease.

Patient Name: ____

Signature: _____________________________________ Date: _____________

Relationship to Patient: ____________________________________