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

PATIENT AQUAINTANCE FORM

Patient Name: ________________________________ Preferred 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 Search ☐Google Ad ☐Facebook ☐Yelp
☐NextDoor ☐Drive By ☐Insurance Company ☐Word of Mouth ☐Other: ____________________________________

>>>>>MEDICAL HISTORY<<<<<

☐TAKE/TOOK BISPHOSPHONATES (Examples: Fosamax, Boniva, Reclast, etc.) If YES, Duration: __________________

☐Osteoporosis (bone density loss)
☐HIV/AIDS diagnosis or exposure
☐Hepatitis
☐Tuberculosis
☐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
☐Anemia
☐Autoimmune Disease
☐Ulcer
☐Kidney Problems
☐Diabetes A1C: _____
☐**OTHER CONDITIONS:** ________________________________
____

☐Blood Problems
☐Arthritis
☐Radiation Treatments
☐Liver 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: _______________
☐Drinker Y or N How many? _____ How often? ______
☐Clenching or Grinding
☐Gums Bleed Easily
☐Teeth Sensitivity (Cold, Heat, Sweets, Pressure)
☐Previous Periodontal Treatment
☐Previous Orthodontic Treatment
☐Unfavorable Dental Experience

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

CURRENT MEDICATIONS AND/OR SUPPLEMENTS:
____
____

PREFERRED PHARMACY: ___________________ **ADDRESS:** _________________________ **PHONE:** ______________
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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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 through Thursday: 9:00AM - 5:00PM
Friday: CLOSED
Saturday by Appointment*
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, Lending Club, or Sunbit

Financing: Care Credit carecredit.com , Lending Club, or Sunbit

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 month prior and a week prior to your appointment and ask that you confirm via phone call, text, or email. Additional contact will be made the day before and day of your appointment.

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 (2 business days) to reschedule or cancel weekday appointments.

Weekday Appointments: There is a **$50 fee** for appointments changed under 48 hours (2 business days).

***Saturday Appointments:** Saturday is scheduled by appointment only and is reserved for treatment procedures. Saturday appointments must be prepaid in advance and the amount is non-refundable.

Financial Responsibility: Payment is ultimately the responsibility of the patient. You are responsible for understanding your insurance benefits and paying the amount your insurance plan does not cover. 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 Plan Estimate will be created for you. Treatment Plan 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. **I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL SERVICES PROVIDED TO ME IN THE EVENT INSURANCE DOES NOT COVER THE COST OF TREATMENT.**

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: ____________________________________

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Patient Financial Responsibility Policy

We are committed to providing you with the highest quality dental care. We ask that you read and sign this form to acknowledge your understanding of our Patient Financial Responsibility Policy.

Payment for services is due on the day of your appointment. Separated or divorced parents of minors, who are responsible for part of the cost of a child/children's dental care: The parent who brings the child/children to the appointment is responsible for paying the balance due.

For your convenience, we accept payments in the form of Cash, Check, Visa, Mastercard, American Express, Discover, Care Credit, Lending Club, or Sunbit. We do not provide in-house payment programs.

If you have insurance, we will submit the fees for your treatment to your insurance company on your behalf for your convenience. It is very important that the correct insurance information is provided at the time of your appointment. If this information changes, it is your responsibility to update our office at the earliest convenience.

While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments by your insurance company. We will provide you with a treatment plan estimate of your out-of-pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee your insurance company will reimburse us according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. We will attempt to gain as many benefits as possible from your insurance for the services provided, but your insurance policy is a contract between you and your insurance company; we are not a party to that contract.

If needed, a pre-determination can be sent to your insurance company to determine what benefit you may receive. Patients are responsible for any 'patient portion' not covered by insurance, which will be due at the time of service. Please be advised, a pre-determination is an estimate and not a promise or guarantee of coverage from the insurance carrier.

We accept assignment of benefits as a courtesy to our patients. Any claim not paid by your insurance carrier within 60 days will be billed to you, the patient. If difficulty arises with payment from the insurance company, we will attempt to appeal the claim. All insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient.

BY MY SIGNATURE BELOW, I HEREBY AUTHORIZE ASSIGNMENT OF FINANCIAL BENEFITS DIRECTLY TO SONORAN VALLEY IMPLANT AND DENTAL CENTER; DR. ROBERT GOMEZ, DDS; AND DR ELIZABETH GOMEZ, DMD. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT. I ACKNOWLEDGE THAT I ASSUME FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED TO ME, IF MY INSURANCE CARRIER DENIES OR DOES NOT COVER MY CLAIM FOR THESE SERVICES. I UNDERSTAND THAT PAYMENT IS DUE FOR SERVICES AT THE TIME OF MY APPOINTMENT. I UNDERSTAND THE TERMS OF THIS FORM AND ACCEPT FINANCIAL RESPONSIBILITY WITH OR WITHOUT THE USE OF INSURANCE COVERAGE.

Patient Name: ____ Date: ____________________________

Signature: ____

Relationship to Patient: ___________________

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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 canal 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 am responsible for understanding my insurance benefits and paying the amount my insurance plan does not cover. I realize that my insurance may help pay part of my treatment costs and that any estimates of insurance benefits quoted to me are *only* estimates and not a guarantee of payment. 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 (2 business days) notice for weekday appointments a $50 fee will be charged. Saturday appointments are by appointment only and must be prepaid in advance and the amount is non-refundable. I also understand that any x-rays and/or CBCTs taken are the property of the dentist and a fee may be charged for duplications or transfer of said imaging.

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 Implant and 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 and/or family members):

Name: _______________________________________ Relationship: ____

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 Implant and Dental Center to use my photo and/or information related to my experiences with Dr. Gomez and/or Sonoran Valley Implant and 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 Implant and Dental Center/Dr. Gomez, without expecting payment. I release Dr. Gomez and Sonoran Valley Implant and 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: ___________________________________