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 ______________________________________

Birthdate _______-_______-_______ 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 _________________________________

Birthdate ________-________-________ 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 Dr. James A. Diamond 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 …………………………………………………………………………………………

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

JAMES A. DIAMOND, D.D.S.
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 either Judy or Lisa 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 Dr. Diamond 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____