Caren P. Hull, D.D.S.
2601 N. Hayden Rd., Scottsdale, AZ 85257
(480) 947-3747

PATIENT ACQUAINTANCE FORM

Name _____ I Prefer To Be called _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Sex (M/F) _____ Date of Birth _____

Social Security # _____ Home Phone _____ Email _____

Employer _____ Marital Status _____ Name of Spouse _____

Name of Responsible Party _____

Billing Address _____

Referred by _____ Insurance Coverage Y / N Name of Company: _____

In case of emergency, notify _____ Phone Number _____

DENTAL HISTORY

Previous Dentist _____ Date of Last Visit _____

Treatment Rendered _____

Last Full Mouth X-Ray _____ Last Complete Exam _____

What Is Your Immediate Concern? _____ Last Dental Cleaning? _____

Are Your Presently In Pain? _____ Have You Ever Had Periodontal Treatment? _____

Interested In Saving Your Teeth? _____ Are You Satisfied With The Appearance Of Your Teeth? _____

Are You Aware Of Your Jaw Clicking or Popping? _____ Does Dental Treatment Make You Nervous? _____

ABOUT US

TREATMENT CONSENT: I hereby consent to the administration of anesthetics, x-rays, photographs, dental treatment, drugs and examination that may be deemed necessary to the above mentioned patient.

MEDICAL/DENTAL INFORMATION RELEASE: My signature hereby authorizes Caren Hull D.D.S., to send to any physician or facility of my choice, requested or pertinent information regarding medical/dental services I have received. It also authorizes Dr. Hull to request medical/dental information about me from any physician and/or facility which has rendered medical/dental care to me.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, "upon receipt of full (or partial) payment bill." We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

APPOINTMENTS: A MINIMUM CHARGE WILL BE MADE FOR FAILED OR CANCELLED APPOINTMENT WITHOUT PRIOR NOTIFICATION OF 24 HOURS.

SERVICE CHARGE: A 1½% monthly service charge may be applied to delinquent accounts after 60 days; this is an annual percentage rate of 18%. In the event of default, I agree to pay all costs and reasonable attorney's fees as may be required to effect collections for dental services performed in this office.

SIGNATURE _____ DATE _____