Patient Name:_____ Date of birth:_____ Sex:_____
Last First Middle Initial

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ E-mail:_____

SS#:_____ Employer:_____

Person Responsible for the account: Self:___ Parent:___ Spouse:____

EMERGENCY CONTACT INFORMATION:

Name:_____ Phone #_____

INSURANCE INFORMATION

_____	_____
Primary Insurance	Secondary Insurance
_____	_____
Subscriber's Name	Subscriber's Name
_____	_____
Birthday SS#	Birthday SS#
_____	_____
Group# ID#	Group# ID#

AUTHORIZATION

I authorize payment directory to Almaden Valley Smile Design of insurance benefits if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not pay by insurance. I authorize the use of my signature on all insurance submission. Dr. Andirious may use my health care information and may disclose such information to the above name insurance company and their agents for the purpose of obtaining payment for the services and determining knowledge. I certify that this information given here is correct to the best of my knowledge.

X_____ _____
Patient or Responsible Party ***Date***

DENTAL HISTORY **PATIENT NAME:**

Date of last dental visit and x-rays_____

Do you have a specific dental problem? _____ Yes No
Do you brush and floss on routine basis? _____ Yes No
Do you have bleeding gums? _____ Yes No
Do you think you have periodontal/gum disease? _____ Yes No
Do you like your smile? _____ Yes No
Do you want to keep your teeth for life time? _____ Yes No
Do you have clicking, popping or discomfort in your jaw joints? _____ Yes No
Do you smoke or chew tobacco? How much? _____ Yes No
Do you feel any sore or growths in your mouth? _____ Yes No
Do you get food collected between your teeth? _____ Yes No
Do you have dry mouth? _____ Yes No
Do you grind or clench your teeth during day or night? _____ Yes No
Have you had any orthodontic treatment? _____ Yes No

MEDICAL HISTORY

Are you under a physicians care now? Why? _____ Yes No
Physician's name and phone number _____
Have you ever been hospitalizes or had a major operation? _____ Yes No
Have you ever had injury to your head and neck? _____ Yes No
Are you on a special diet? Explain _____ Yes No
Are you allergic to any kind of medications or substance? please check below
__ Aspirin __Local Anastasia __Penicillin __Codeine __Acrylic __Latex __Sulfa Drug __Peanuts
__ Milk __Other _____
Women Please check if you are __ pregnant __Nursing Taking Oral Contraceptives _____ Yes No
Are you currently on any medications? Please list your medications _____
_____

	Y	N
Heart Disease	__	__
Heart Murmur/Defect	__	__
Irregular Heart Beat	__	__
Angina/ Chest Pain	__	__
Heart Attack	__	__
Mitral Valve Prolepses	__	__
Scarlet Fever	__	__
Rheumatic Fever	__	__
Artificial Heart Valve	__	__
Heart Pace maker	__	__
Pulmonary Shunt	__	__
High Blood Pressure	__	__
Low Blood Pressure	__	__
Bacterial Endocarditis	__	__
Blood Disorder	__	__
Anemia Coronary	__	__
Shortness of Breath	__	__
Frequent Cough	__	__
Hay Fever	__	__
Sinus Trouble	__	__
Bloody Sputum	__	__
Sickle Cell Disease	__	__
Cholesterol	__	__

	Y	N
Excessive Bleeding	__	__
Leukemia	__	__
Blood Transfusion	__	__
Lung Disease	__	__
Swollen Feet/ Ankles	__	__
Asthma	__	__
Breathing Problems	__	__
Emphysema	__	__
Tuberculosis	__	__
Cancer	__	__
Chemotherapy	__	__
Radiation Treatment	__	__
Osteoporosis	__	__
Bisphosphonates	__	__
Fosamax,Actonel,Boniva	__	__
Ulcers	__	__
Diabetes	__	__
Liver Disease	__	__
Hepatitis A	__	__
Hepatitis B	__	__
Hepatitis C	__	__
Jaundice	__	__
Kidney Problems	__	__

	Y	N
Thyroid Disease	__	__
Arthritis	__	__
Renal Dialysis	__	__
Rheumatism	__	__
Cortisone Treatment	__	__
Artificial Joints	__	__
STD	__	__
AIDS	__	__
HIV Positive	__	__
Couchlear Implant	__	__
Alcoholism	__	__
Herpes	__	__
Stroke	__	__
Seizures/Epilepsy	__	__
Fainting/Dizziness	__	__
Glaucoma	__	__
Tumors/Growths	__	__
Nervousness	__	__
Psychiatric care	__	__
Alzheimer's disease	__	__
Ever taken fen-phen	__	__

Cancellation Policy

We appreciate our patients and their time. We know that last minute emergencies may arise. However, our office policy is that you notify us at least 48 hours prior to your appointment if you will not be able to keep your reserved time. For your convenience, we do call to confirm your appointment 48 hours in advance. Since the office is closed on Fridays, we will call to confirm your appointment on the Thursday before your are schedule in our office. Please keep in mind that this is a courtesy call and if the appointment you reserved is not cancelled by our required 48 hours policy there will be a $50.00 charge. We thank you for your cooperation.

Sincerely,

Almaden Valley Smile Design

I have read and understand the above mentioned policy.

Patient Signature

Date

6472 Camden Avenue, Suite 100 • San Jose, CA 95120 • 408-997-9027 • ClaraAndiriousDDS.com