Silicon Valley Center for Cosmetic Dentistry
1565 Hollenbeck Ave #112
Sunnyvale, CA 94087

Registration and History

Date:_____ Patient Name:_____
Address:_____ Sex: ☐ Male ☐ Female
City:_____State:_____ Zip Code:_____
Date of Birth:_____ Social Security:_____ Email:_____
Employer:_____Occupation:_____
Spouse/Parent/Guardian Name:_____ Date of Birth:_____
Social Security:_____ Employer:_____

Who can we thank for referring you?_____

Contact Information

Home Phone Number: _____ Work Phone Number:_____
Cell Number:_____ Spouse Phone Number:_____
Please update any changes of contact information, mailing address or insurance immediately

Dental Insurance Information

Subscriber Name:_____ Subscriber ID Number:_____
Subscriber Date of Birth: _____Relationship to Patient:_____
Insurance Company:_____ Group Number:_____
*If patient is covered by another dental insurance please check, ☐ No ☐ If yes, fill in the following.

Subscriber Name:_____ Subscriber ID Number:_____
Subscriber Date of Birth: _____ Relationship to Patient:_____
Insurance Company:_____ Group Number:_____

HIPPA

The HIPPA privacy rule provides federal protection for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the privacy rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. The security rule specifies a series of administrative, physical and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity and availability of electronic protected health information.

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with insurance co:_____ and assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature in all insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Please print name of Patient:_____
Signature of Patient/Parent/Guardian:_____
Date:_____Relationship to Patient:_____

Silicon Valley Center for Cosmetic Dentistry
Gabriel Cano, DDS
Office Policies

Forms
New Patient Forms and Medical Update Forms should be filled out and submitted electronically before your scheduled appointment. This allows the office to prepare your forms. If you are unable to fill out the forms electronically, we ask you to arrive 30 minutes before your scheduled appointment time to fill the forms here in our office.

Intra Oral Photos
Intra oral photographs are taken in the office as a tool to aid in the diagnosis of caries, broken teeth, faulty restorations, fracture lines, etc. They help educate the patient and also work as a supporting document/proof to submit to insurance when treatment is needed or has been done. Some insurance policies cover the intra oral photographs. If insurance does not cover, it is the patient's out of pocket expense. The cost is $40.

Patient Initials: _____

Regarding Insurance
For those patients covered by insurance, we are happy to extend the courtesy of billing your insurance company for you; provided we are supplied with all of the necessary information to do so. We do however, require payment of your estimated portion at the time of service. Please know that this is an estimate, based on information we get from your dental insurance company over the phone, Internet or fax. Insurance does not guarantee any information they provide us and final determination is done when they process your dental claim. If your insurance company does not make payment within 30 days, you will be expected to investigate this claim and clear any balance with our office. Your insurance policy is contracted between you and your insurance company. Please remember by providing full and accurate information regarding your insurance carrier, you facilitate successful proceedings of your claims.

Usual and Customary Rates
Our practice is committed to providing the best treatment to our patients and we charge what is usual and customary for our area. You are responsible for payment of our appropriate fee regardless of any insurance company's arbitrary determination of usual and customary rates. We are a fee for service office. Payment is due on the day of service. We accept Cash, Visa, MasterCard or Check.

Past Due Accounts
We forward all accounts over 60 days to a collection agency for processing

Confirming Appointments and Cancellation Policy
The office will reach out to you either by phone call, text message, or email to confirm your scheduled appointment one week in advance. Please reply to the message and confirm. If you need to communicate with the office, you can call us at (408) 739-9047. If you call outside of our normal business hours, a live answering service will answer and take your call. They will take a message for the office. ***If you have a dental emergency, please call (408) 739-9047 and Dr. Cano will be contacted.*** The office has a texting number (408) 475-6751 that is for *text messages only, no phone calls*. Our office email is gabrielcanodds@gmail.com and is checked only during business hours. The office is closed Fridays, Saturdays, Sundays and most holidays. Your appointment time is reserved for you. If canceling/rescheduling without a 48 hour notice or failing to show up to your appointment: A $100 fee per appointment hour will be applied to you.

For All Patients
I hereby authorize the doctor to take radiographs, study models, photographs or any diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I also authorized the doctor to prescribe any and all forms of medication and perform any therapy that may be indicated and agreed upon. I understand that during treatment, It may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. I give my permission to the doctor to make any changes and additions as necessary. I agree to pay for all services rendered by this office. I have read and I understand the office policies and concur.

Printed Name_____
Date_____Signature_____

Dental History Form

Patient Name: _____ Date of Birth: _____

Date of Last Dental Visit? ____/____/____ Reason for the Visit? _____

Date of Last Dental X-rays? ____/____/____

Former Dentist: _____ Phone: _____

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

If you left your previous dentist, what was the reason? _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

At-Home Oral Hygiene Care

How often do you brush your teeth? _____

How often do you floss? _____

Do you use mouthwash? ☐ Yes/No ☐

If YES, which kind: _____

Do you use any other dental home care products? ☐ Yes/No ☐

If YES, which kind: _____

Choose Appropriate Answer

1. Are you currently experiencing dental pain or discomfort? ☐ Yes/No ☐

   If YES, explain: _____

2. Do your gums bleed? ☐ Yes/No ☐

   If YES, explain: _____

3. Are your teeth loose? ☐ Yes/No ☐

   If YES, explain: _____

4. Do you wear dentures or partials? ☐ Yes/No ☐

   If YES, explain: _____

5. Have you ever been told you have gum disease? ☐ Yes/No ☐

   If YES, explain: _____

6. Are your teeth sensitive to hot, cold, sweets or pressure? ☐ Yes/No ☐

   If YES, explain: _____

7. Have your ever had any clicking, popping or discomfort in the ¡aw? ☐ Yes/No ☐

   If YES, explain: _____

8. Do you brux or grind your teeth? ☐ Yes/No ☐

If YES, explain: _____

9. Do you wear an occlusal guard? ☐ Yes/No ☐

10. Have you ever had orthodontic treatment (braces, etc) before? ☐ Yes/No ☐

If YES, explain: _____

11. Do you have a dry mouth? ☐ Yes/No ☐

12. Does food or floss catch between your teeth? ☐ Yes/No ☐

If YES, explain: _____

13. Have you had any problems or an upsetting dental experience associated with previous dental care? ☐ Yes/No ☐

YES, explain: _____

14. Are you fearful of dentistry or have anxiety associated with dental treatment? ☐ Yes/No ☐

If YES, explain: _____

15. Have you ever been pre-medicated for dental treatment? ☐ Yes/No ☐

If YES, explain: _____

16. Have you ever had a reaction to anesthetic used with your dental treatment? ☐ Yes/No ☐

If YES, explain _____

17. Are you happy with your smile? ☐ Yes/No ☐

If NO, please explain: _____

18. What would you change about the present condition of your mouth? _____

19. Is there anything else you would like us to know about your dental health or dental history? ☐ Yes/No ☐

If YES, explain: _____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

_____ _____

Signature of Patient (Parent or Guardian) Date

_____ _____

Signature of Dentist Date

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. ☐ Yes / No ☐ Is your general health good?
   If NO, explain: _____
2. ☐ Yes / No ☐ Has there been a change in your health within the last year?
   If YES, explain: _____
3. ☐ Yes / No ☐ Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. ☐ Yes / No ☐ Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____
5. ☐ Yes / No ☐ Have you had problems with prior dental treatment? Reason for exam: _____
   If YES, explain: _____
   Date of last dental exam: _____ Name of last treating dentist: _____
6. ☐ Yes / No ☐ Are you in pain now?
   If YES, explain: _____

II. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING? (Please check Yes or No for each)

- ☐ Yes / No ☐ Chest pain (angina)
- ☐ Yes / No ☐ Fainting spells
- ☐ Yes / No ☐ Recent significant weight loss
- ☐ Yes / No ☐ Fever
- ☐ Yes / No ☐ Night sweats
- ☐ Yes / No ☐ Persistent cough
- ☐ Yes / No ☐ Coughing up blood
- ☐ Yes / No ☐ Bleeding problems
- ☐ Yes / No ☐ Blood in urine
- ☐ Yes / No ☐ Blood in stools
- ☐ Yes / No ☐ Diarrhea or constipation
- ☐ Yes / No ☐ Frequent urination
- ☐ Yes / No ☐ Difficulty urinating
- ☐ Yes / No ☐ Ringing in ears
- ☐ Yes / No ☐ Headaches
- ☐ Yes / No ☐ Dizziness
- ☐ Yes / No ☐ Blurred vision
- ☐ Yes / No ☐ Bruise easily
- ☐ Yes / No ☐ Frequent vomiting
- ☐ Yes / No ☐ Jaundice
- ☐ Yes / No ☐ Dry mouth
- ☐ Yes / No ☐ Excessive thirst
- ☐ Yes / No ☐ Difficulty swallowing
- ☐ Yes / No ☐ Swollen ankles
- ☐ Yes / No ☐ Joint pain or stiffness
- ☐ Yes / No ☐ Shortness of breath
- ☐ Yes / No ☐ Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please check Yes or No for each)

- ☐ Yes / No ☐ Heart disease
- ☐ Yes / No ☐ Family history of heart disease
- ☐ Yes / No ☐ Heart attack
- ☐ Yes / No ☐ Artificial joint
- ☐ Yes / No ☐ Stomach problems or ulcers
- ☐ Yes / No ☐ Heart defects
- ☐ Yes / No ☐ Heart murmurs
- ☐ Yes / No ☐ Rheumatic fever
- ☐ Yes / No ☐ Skin disease
- ☐ Yes / No ☐ Hardening of arteries
- ☐ Yes / No ☐ High blood pressure
- ☐ Yes / No ☐ Seizures
- ☐ Yes / No ☐ Cosmetic surgery
- ☐ Yes / No ☐ AIDS/HIV
- ☐ Yes / No ☐ Surgeries
- ☐ Yes / No ☐ Hospitalization
- ☐ Yes / No ☐ Diabetes
- ☐ Yes / No ☐ Family history of diabetes
- ☐ Yes / No ☐ Tumors or cancer
- ☐ Yes / No ☐ Chemotherapy
- ☐ Yes / No ☐ Radiation
- ☐ Yes / No ☐ Arthritis, rheumatism
- ☐ Yes / No ☐ Emphysema or other lung disease
- ☐ Yes / No ☐ Liver disease
- ☐ Yes / No ☐ Kidney or bladder disease
- ☐ Yes / No ☐ Stroke
- ☐ Yes / No ☐ Eating disorders
- ☐ Yes / No ☐ Psychiatric care
- ☐ Yes / No ☐ Osteoporosis
- ☐ Yes / No ☐ Thyroid disease
- ☐ Yes / No ☐ Asthma
- ☐ Yes / No ☐ Hepatitis
- ☐ Yes / No ☐ Sexual transmitted disease
- ☐ Yes / No ☐ Herpes
- ☐ Yes / No ☐ Canker or cold sores
- ☐ Yes / No ☐ Anemia
- ☐ Yes / No ☐ Eye disease
- ☐ Yes / No ☐ Transplants
- ☐ Yes / No ☐ Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please check Yes or No for each)

- ☐ Yes / No ☐ Aspirin
- ☐ Yes / No ☐ Penicillin or other antibiotics
- ☐ Yes / No ☐ Nitrous oxide
- ☐ Yes / No ☐ Metal
- ☐ Yes / No ☐ Valium or sedatives
- ☐ Yes / No ☐ Latex
- ☐ Yes / No ☐ Codeine or other opioids
- ☐ Yes / No ☐ Food
- ☐ Yes / No ☐ Local anesthetic

Other: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

☐ Yes / No ☐ Recreational drugs
☐ Yes / No ☐ Over-the-counter medicines
☐ Yes / No ☐ Weight loss medications
☐ Yes / No ☐ Anti-Depressants
☐ Yes / No ☐ Tobacco in any form
☐ Yes / No ☐ Alcohol
☐ Yes / No ☐ Bisphosphonate (Fosamax)
☐ Yes / No ☐ Herbal supplements
☐ Yes / No ☐ Antibiotics
☐ Yes / No ☐ Supplements
☐ Yes / No ☐ Aspirin

☐ Yes / No ☐ Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

☐ Yes / No ☐ Are you or could you be pregnant? If YES, what month? _____
☐ Yes / No ☐ Are you nursing?
☐ Yes / No ☐ Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

☐ Yes / No ☐ Do you have or have you had any other diseases or medical problems NOT listed on this form?

If **Y**es, please explain: _____

☐ Yes / No ☐ Have you ever been pre-medicated for dental treatment? If YES, why: _____

☐ Yes / No ☐ Have you ever taken Fen-Phen? If YES, when: _____

☐ Yes / No ☐ **Is there any issue or condition that you would like to discuss with the dentist?**

If Yes, what?: _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

Whom would you like us to contact in case of an emergency?):

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian)	Date	Signature of Dentist	Date
_____	_____	_____	_____

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Gabriel Cano DDS A Dental Corp
1565 Hollenbeck Ave, Suite 112
Sunnyvale, CA 94087
408-739-9047

Consent to Electronic Transmission of Communication

I, _____ consent to electronic transmission of communication by Gabriel Cano DDS A Dental Corp. By signing this form, I give consent to receive communication by email or text messages.

I acknowledge I can request if I do not want and/or prefer a specific type of transmission.
By signing this Consent to Electronic Transmission of Communication, I consent to the electronic transmission of any and all communication from Gabriel Cano DDS A Dental Corp.

_____ _____

Signature of Patient (Parent or Guardian) Date