Dr. Cheryl G. Vicencio
Dentistry for Children & Adults

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Cheryl G. Vicencio, D.M.D.
753 Saratoga Ave,
San Jose, CA 95129

*** WELCOME ***

ABOUT YOU

Todays Date: ___/___/____

NAME: _____
Last First MI

I prefer to be called: _____ ☐Male ☐Female

Birthdate: ___/___/___ Age: _____ SS#: _____-_____-_____

Home Address: _____
No. Street Apt #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐Widowed ☐ Separated

Home Phone: (___) ___-_____ CELL #: (___)___-_____

Work Phone: (___) ____ -_____ Ext: _____

E-Mail Address: _____@_____

EMPLOYER: _____

Employer's Address: _____

_____

Years in Service: _____ Occupation: _____

Referred By: _____

Person to be notified in case of Emergency:_____

Relationship:_____Contact Phone #: (___)____-_____

SPOUSE INFORMATION

His / Her Name: _____

Employer : _____

Work Phone: (___) ___-_____ SS#:_____-____-_____

Birthdate: ___/___/___

PERSON RESPONSIBLE FOR ACCOUNT:_____

Phone Number: (___) ____-_____

Billing Address: _____

Relationship :_____ SS#: _____-____-_____

INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____-_____

Group # (Plan Local or Policy #) _____

Insured's Name: _____ Relation:_____

Insured's Birthdate: ___/___/___ Insured's SS#: _____-_____-_____

Insured's Employer: _____

Employer's Address: _____

_____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___) _____-_____

Group # (Plan Local or Policy #) _____

Insured's Name: _____ Relation:_____

Insured's Birthdate: ___/___/___ Insured's SS#: _____-_____-_____

Insured's Employer: _____

Employer's Address: _____

MEDICAL HISTORY

Have you been under the care of a medical doctor in the past two years? ☐ Yes ☐ No

If yes, for what?_____

Physician's Name:_____

Physician's Phone #: (___) _____-_____

Have you taken medication or drugs during the past two years? ☐ Yes ☐ No

Are you taking any medication, drugs or pills now? ☐ Yes ☐ No

If yes, please list names & dosage _____

BISPHOSPHONATES (Actonel, Aredia, Boniva, Didronel, Fosamax, Reclast, Skelid, Zometa) ? ☐ Yes ☐ No

continued on back

MEDICAL HISTORY continued

Have you ever taken prescription medications for weight loss? ☐ Yes ☐ No

If yes, did you take any of the following;

☐ Fen-Phen ☐ Pondimen ☐ Redux

Did you have a medical exam for heart issues? ☐ Yes ☐ No

FOR WOMEN: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Months :_____

Are you nursing? ☐ Yes ☐ No

Place a check mark on the ☐ of any of the following which you have had or have at present:

☐ Heart Surgery,Disease, Attack
☐ Congenital Heart Disease
☐ Angina Pectoris (chest pain)
☐ Thyroid Disease
☐ Radiation Therapy
☐ Arthritis / Rheumatism

☐ High Blood Pressure
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Contact Lenses
☐ Cortisone Medicine
☐ Glaucoma

☐ Rheumatic Fever
☐ Scarlet Fever
☐ Artificial Heart Valve
☐ Aids / HIV Positive
☐ Hepatitis A (infectious)
☐ Hepatitis B (serum)

☐ Heart Pacemaker
☐ Swollen Ankles
☐ Chemotherapy (cancer, leukemia)
☐ Tumors
☐ Liver Disease
☐ Yellow Jaundice

☐ Artificial joints (hip, knee etc)
☐ Anemia
☐ Stroke
☐ Blood Transfusion
☐ Alcohol / Drug Abuse
☐ Hemophilia

☐ Kidney Trouble
☐ Venereal Disease(syphillis,gonorrhea)
☐ Cold Sores / Fever Blisters
☐ Ulcers
☐ Neurological Disorders
☐ Emphysema

☐ Chronic Cough
☐ Tuberculosis (TB)
☐ Nervousness / Anxiousness
☐ Epilepsy / Seizures
☐ Fainting or Dizzy Spells
☐ Asthma

☐ Hay Fever
☐ Sinus Trouble
☐ Allergies or Hives
☐ Psychiatric Treatment
☐ Sickle Cell Disease
☐ Bruise Easily

☐ Diabetes
☐ Diet (special / restricted)

Please list any medical condition you have had but is not identified above.

_____

Are you allergic to any of the following?

☐ Aspirin ☐ Erythromycin ☐ Tetracycline ☐ Codeine
☐ Latex ☐ Penicillin ☐ Dental Anesthetics ☐ Others

_____

FOR OFFICE USE ONLY * FOR OFFICE USE ONLY
Medical Updates:

1._____
2._____
3._____
4._____
5._____

DENTAL HISTORY

Reason for today's visit :_____

_____

Former Dentist: _____

Address: _____

Date of Last Visit:__/__/__ Date of last dental X-rays:__/__/__

Check if you have had any of the following:

☐ Bad Breath ☐ Grinding Teeth ☐ Sensitivity to heat
☐ Bleeding Gums ☐ Periodontal Treatment ☐ Sensitivity to sweets
☐ Clicking or popping jaw ☐ Sensitivity when biting
☐ Food collection between teeth ☐ Sensitvity to cold
☐ Loose Teeth or broken fillings ☐ Sores or growths in your mouth

How often do you floss? _____ times a day

How often do you brush ? _____times a day

Do you like your smile? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Payment in full at the time of treatment unless prior arrangements have been made.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

I hereby authorize payment directly to Dr. Cheryl G. Vicencio D.M.D. of insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

I also understand that a $25.00 broken appointment fee may be charged for missed appointments and less than 24 hours cancellation notices.

I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance Company.

_____

Patient's or Responsible Party Signature **Date**

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6._____
7._____
8._____
9._____
10._____