

# WELCOME

## FROM THE OFFICE OF DR. YOLANDA CINTRON

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

### I- ABOUT YOU:

1. Today's date: \_\_\_\_\_
  2. DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_
  3. NAME: \_\_\_\_\_
  4. ADDRESS: \_\_\_\_\_
  5. CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_
  6. PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_
  7. E-MAIL: \_\_\_\_\_ BEEPER# \_\_\_\_\_
  8. WHEN IS THE BEST TIME TO CALL YOU: \_\_\_\_\_ AND WHERE? \_\_\_\_\_
  9. SINGLE \_\_\_ MARRIED \_\_\_ DIVORCED \_\_\_ WIDOWED \_\_\_ SEPARATED \_\_\_\_\_
  10. EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_
  11. ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_
  12. STATE/ZIP: \_\_\_\_\_ PHONE #: \_\_\_\_\_
  13. SPOUSE'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_
  14. SPOUSE'S WORK # \_\_\_\_\_
  15. WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_
  16. SPECIAL INTEREST OR HOBBIES: \_\_\_\_\_
  17. TYPE OF MUSIC AND READING MATERIAL YOU LIKE: \_\_\_\_\_
  18. WHAT DO YOU LIKE TO BE CALLED? \_\_\_\_\_
  19. IN CASE OF AN EMERGENCY, WHO MAY WE CONTACT \_\_\_\_\_
- NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

**II DENTAL HISTORY**

- 1. What would you like us to do today? \_\_\_\_\_
- 2. Are you in any dental discomfort today? \_\_\_\_\_
- 3. Former Dentist \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_
- 4. Why did you leave your last dentist? \_\_\_\_\_

- 5. How was your experience: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_
- 6. Date of last dental care \_\_\_\_\_ Date of last x-rays \_\_\_\_\_

- 7. Have you had problems with any of the following:
- Y/N Bad Breath \_\_\_\_\_ Y/N Clicking or popping jaw \_\_\_\_\_
- Y/N Food Collection between teeth \_\_\_\_\_ Y/N Grinding or clenching teeth \_\_\_\_\_
- Y/N Loose teeth or broken fillings \_\_\_\_\_ Y/N Periodontal treatment \_\_\_\_\_
- Y/N Sensitivity to hot/cold/sweets \_\_\_\_\_ Y/N Sores/growths in mouth \_\_\_\_\_
- Y/N Bleeding gums \_\_\_\_\_ Y/N Bruise easily \_\_\_\_\_

8. How would you describe the condition of your teeth and gums.  
 Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Are you having any discomfort with your teeth or gums? Y/N If yes please explain: \_\_\_\_\_

- 9. Do your gums bleed when you brush your teeth? Y/N or Floss Y/N \_\_\_\_\_
- 10. How often do you brush your teeth? \_\_\_\_\_ Floss your teeth? \_\_\_\_\_
- 11. Have you ever experienced pain in your jaw joint? Y/N \_\_\_\_\_
- 12. Do you grind your teeth? Y/N \_\_\_\_\_
- 13. Have you ever been treated for TMJ / Jaw symptoms? Y/N If yes please explain \_\_\_\_\_

14. If you could change your smile, what would you change? \_\_\_\_\_

15. What do you consider to be the most important factor in making sure that your dental experience is a positive one? \_\_\_\_\_

16. What are your goals and desires regarding your dental health? \_\_\_\_\_

**AUTHORIZATION**

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Yolanda Cintron to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I will be responsible for any collection costs and attorney fees if I fail to honor my financial obligation for my dental treatment.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_ (parent or guardian, if patient a minor)

Dentist

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No  N/A \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No  N/A \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No  N/A \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No  N/A \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No  N/A \_\_\_\_\_
- Do you use tobacco?  Yes  No  N/A \_\_\_\_\_
- Are you on a special diet?  Yes  No  N/A \_\_\_\_\_
- Do you use controlled substances?  Yes  No  N/A \_\_\_\_\_
- Women: Are you  Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following? \_\_\_\_\_

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_

Do you have, or have you had, any of the following? \_\_\_\_\_

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive       | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease     | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout          | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur*         | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker*     | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint*       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints     | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem       | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss     | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis         | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever*       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No  N/A \_\_\_\_\_

Comments: \_\_\_\_\_

\*Condition may require medication N/A - Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT, or GUARDIAN

\_\_\_\_\_  
DATE

## **THE FIVE LEVELS OF DENTAL CARE**

### **We offer to people who choose our practice**

We understand that choosing a new dental health team can be challenging, and may leave you feeling somewhat uncertain. We welcome you, and would like to share our beliefs about how we feel patients should be treated.

#### **Mission Statement**

“Our purpose is to help each individual achieve the highest level of well-being possible, thus enhancing the quality of their lives. By accomplishing this, it enhances ours as well.”

We will help you reach the level that you seek. This is a major departure from the way we were trained. Instead of telling you how healthy you ought to be, we will help you to understand your choices about dental health, to enable you to make an informed decision. There are five levels to choose from as to your preference of treatment. We expect you to inform us which one suits you best.

**Level 1...URGENT CARE...**People in crisis with an urgent problem such as pain, swelling, or bleeding and need immediate help. We see emergencies immediately, whenever possible.

**Level 2...REMEDIAL CARE...**People who choose this level of care desire treatment only when something breaks or becomes uncomfortable. Generally, people at this level prefer brief examinations, screening for obvious, or more advanced problems. They usually want to resolve problems with little effort or cost, even though the treatment plan may not be a long term solution. People at this level are not yet ready for a comprehensive examination and long term treatment plan. Their motto might be “Let’s just take care of what is wrong today and not worry about tomorrow”. This type of patient does not treat the health of the mouth as it relates to the health of the body.

**Level 3...SELF-CARE...**People will choose this level if they want to achieve comfort, function, and an excellent appearance. People at this level choose to have a comprehensive examination, fully evaluating teeth, gums and supporting tissues, as well as the relationship of the jaw to overall dental health.

During this examination, we will work together with you to plan for your long term dental care. However due to current personal circumstances, these people are unable to move forward with the optimal treatment plan. They will accept a treatment plan to maintain their condition until they are able to proceed to a higher level. They are interested in how they can personally improve their dental health and arrest any active disease processes, but are not yet ready to commence with major treatment. People at this level are monitored through frequent preventive maintenance visits with our hygienists.

**Level 4...COMPLETE DENTISTRY...**People at this level are similar to the people described above. They choose to have a comprehensive examination and formulate a long term treatment plan, designed to achieve a dental future of choice not chance. Unlike the self-care person they are ready to commence treatment. They also want to understand and control the causative agents of dental disease. Again, they are interested in prevention, and interface closely with our hygiene department before, during and after treatment.

**Level 5...WELLNESS RESOURCE...**People here are in excellent dental health. They want to see the hygienist at least four times per year with complete monitoring examinations done annually by the dentist. These people practice highly effective levels of nutrition, home care, and maintain a healthy lifestyle. We assist these people in finding others in the community who might help them to attain even higher levels of personal well-being.

Some people begin at a lower level and progress over time. If we can help with your decision regarding the level that is the most comfortable for you to begin, please call us. We thank you for the opportunity to provide your dental care.

Yours for better health and well-being,  
Yolanda Cintron, D.M.D. and her Dental Health Team