



Welcome! 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.

1. Today's date: _____

2. Date of Birth: _____

Age: _____

3. Name: _____

4. Address: _____

5. City: _____

State: _____ Zip Code: _____

6. Cell Phone: _____

Home Phone: _____

7. Work Phone: _____

8. Personal E-mail: _____

Business E-mail: _____

9. What is the best way to contact you? E-mail Cell Phone TXT Message Work

Best Time: AM PM

10. (Please Check One) Single Divorced Widowed Married Separated

11. Employer: _____ Occupation: _____

12. Address: _____

City: _____ State: _____ Zip: _____

13. Spouse's Name: _____

14. Spouse's Cell Phone: _____ Spouse's Work Phone: _____

15. Whom may we thank for referring you? _____

16. How did you hear about us? _____

17. Special interest or hobbies: _____

18. Type of music & reading material you like: _____

19. Any major events or life changes occurring this year: _____ When? _____

Wedding Anniversary Graduation Plastic Surgery Trip - Where? Work Promotion

20. Favorite Food: _____

21. Favorite Color: _____

22. What name do you like to be called? _____

23. In case of emergency who should we contact? _____ Relationship to you: _____

Name: _____ Contact Number: _____

24. Is there something you would like us to pray for today with you? _____

Dental History

1. What would you like us to do today?

2. What would you like us to do in the near future?

3. Please describe your ideal dentist

4. Are you in any dental discomfort today?

5. Former Dentist

City

State

6. Why did you leave your last dentist?

7. How was your last dental experience? Excellent Good Fair Poor

8. Date of last Dental Care:

Date of last X-Rays:

9. Have you had problems with any of the following:

Yes No Bad Breath Morning Evening Menstrual Cycle

Yes No Grinding or Clenching Teeth Headaches

Yes No Periodontal Treatment Year: _____

Yes No Bruise Easily

Yes No Bleeding Gums When Flossing Spitting Dental Cleanings

Yes No Clicking or popping jaw

Yes No Loose teeth or broken fillings Location: _____

Yes No Sores/ Growths in your mouth

Yes No Food collection between teeth

Yes No Sensitivity

Yes No Herpes lesion Cold Sores When: _____

Yes No Aftos ulcers

Yes No Dry mouth

10. How would you describe the condition of your teeth and gums? Excellent Good Fair Poor

11. How long would you like to have your teeth? 5 Years 10 Years 20+ Years

12. Has a dentist given you a mouth guard? Yes No

13. Are you using it? Yes No

14. Are you happy with your teeth color? Yes No

15. Are you happy with your teeth shape? Yes No

16. Are you happy with your teeth size? Yes No

17. How often do you brush your teeth?

18. What do you consider the most important factor in making sure that your dental experience is a positive one?

19. 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 the 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.

Signature: _____ Date: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you
 Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

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 _____

HIPPA Notice of Privacy Practices

Dr. Yolanda Cintron

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE READ AND REVIEW CAREFULLY

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical, dental or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the dentist/physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We will also disclose to a family member, spouse, adult children, and information as necessary for your overall dental care. By signing this document, you give permission to share your dental health information with any family member, friend or other persons to the extent necessary to help with your healthcare and/or with payment for your healthcare. For example: we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example would be when we would need to share your records of information to a specialist or a physician to whom you have been referred to, to ensure that the physician or specialist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health/dental care services, including from your family members or friends. For example: obtaining approval for a dental procedure from an insurance carrier that may require that your relevant protected health information be disclosed to the insurance plan to obtain approval for the procedure.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review, activities, training of medical/dental students, licensing, and conducting or arranging for other business activities. For example: we may disclose your protected health information as necessary to contact you to remind you of your appointment via mail or by phone.

We may use or disclose your protected health information in the following situations without your authorization: These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight Abuse or Neglect, Food and Drug Administration requirements, Legal Proceeding, Law Enforcement, Coroners, Funeral Directors, Organ Donation services, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation. Under the law, we must determine our compliance with the requirements of Section 164.500.

Your rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in , a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may b involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply in writing.

Your physician/dentist is not required to agree to a restriction that you may request. If physician/dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician/dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. **We will not retaliate against you for filing a complaint.**

This notice was published and became affected on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number 954-938-4599

I, _____, have received a copy of the above Notice of Privacy Practices from this office and give my permission to all of the above.

_____ Date: _____
Please Print Name

_____ Date: _____
Signature

You may refuse to sign this acknowledgment

If refusing: _____ Date: _____
Signature

**INTERNATIONAL CENTER FOR DENTAL EXCELLENCE
DR. YOLANDA CINTRON D.M.D**

NAME, LIKENESS, AND/OR VOICE RELEASE

_____ In connection with the production of photographs, images and/or film or videotape currently referred to as production of same, I hereby agree that, Yolanda Cintron, D.M.D.; International Center For Dental Excellence hereinafter referred as (“you”) may use my words, my voice and/or my image as well as my live performance and you may film, videotape, photograph and record me that you shall be exclusive owner of the results and proceeds thereof with the right, forever and throughout the world, to use and edit my name, picture, characterization, performance, words and voice in any and all media, now and hereafter known including without limitation, theatrical, print, television, radio and video, computer and Internet and in connection with the publication of or exhibition theatrically of whether live or recorded, on television, in print or otherwise, of any photograph, quotation, motion picture, video tape, or other form of marketing, advertising or public relations in which the same may be incorporated and in the advertising, exploitation, sale or publicity and promotion of any such performance or personal appearance or publication, of any photograph, motion picture, videotape, or sound recording, or legal reasons example: court use, or product associated therewith.

I warrant and represent that I have read the foregoing and fully understand the meaning and effect thereof and, intending to be legally bound, I have signed this release

_____ day of _____ 200_____

I am over 18 years of age. Yes _____ No _____

Name and Address:

Phone#: _____

Patient Signature

Date

**INTERNATIONAL CENTER FOR DENTAL EXCELLENCE
DR. YOLANDA CINTRON D.M.D**

NAME, LIKENESS, AND/OR VOICE RELEASE

_____ I permit the use of my voice, photographs, motion picture, and or video, only for office, case study purposes and legal court proceedings. It will also be to diagnose, develop a treatment plan and communicate with labs. I do not permit Dr. Yolanda Cintron D.M.D: International Center For Dental Excellence to use any of this material publicly or for any type of marketing, publicity, and/or promotion of any kind.

I warrant and represent that I have read the foregoing and fully understand the meaning and effect thereof and, intending to be legally bound, I have signed this release

_____ day of _____ 200_____

I am over 18 years of age. Yes _____ No _____

Name and Address:

Phone#: _____

Patient Signature

Date