



PATIENT REGISTRATION

PATIENT INFORMATION:

Date: ____ / ____ / ____

Mr. Mrs. Ms. Dr.

First Name: _____ Last Name: _____ MI: ____ Nickname: _____

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

Home #: (____) _____ Mobile #: (____) _____ Other #: (____) _____

Sex: Female Male

Marital Status: Married Single Divorced Separated Widowed

Birth date: ____ / ____ / ____

Age: _____

ID / Drivers License#: _____ - _____ - _____

E-mail: _____

I'd like to receive e-mail correspondences

Who may we thank for referring you? _____

What would you like for us to pray for you? _____

Employment Status: Full Time Part Time Self Employed Retired Unemployed

Student Status: Full Time Part Time

EMERGENCY CONTACT:

First Name: _____ Last Name: _____ Home #: (____) _____

Mobile #: (____) _____ Other #: (____) _____ Pharmacy #: (____) _____

PHYSICIAN'S INFORMATION:

Physician's Name: _____

Date of your last physician visit: ____ / ____ / ____

Specialty: Gen. Physician Oncologist Alternative Med. (Holistic) Cardiologist Chiropractor Other _____

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

Office #: (____) _____ Mobile #: (____) _____ Other #: (____) _____

Additional info / treatments: _____

Alternative Care doctor: _____ Last visit: ____ / ____ / ____ City, State: _____ Office #: (____) _____

Cardiologist: _____ Last visit: ____ / ____ / ____ City, State: _____ Office #: (____) _____

Endocrinologist: _____ Last visit: ____ / ____ / ____ City, State: _____ Office #: (____) _____

Chiropractor: _____ Last visit: ____ / ____ / ____ City, State: _____ Office #: (____) _____

Oncologist: _____ Last visit: ____ / ____ / ____ City, State: _____ Office #: (____) _____

Neurologist: _____ Last visit: ____ / ____ / ____ City, State: _____ Office #: (____) _____

Physical Therapist: _____ Last visit: ____ / ____ / ____ City, State: _____ Office #: (____) _____

Acupuncturist: _____ Last visit: ____ / ____ / ____ City, State: _____ Office #: (____) _____

MEDICAL HISTORY

Although we primarily treat the area in and around your mouth, we know that your mouth is a part of your entire body.

Existing health problems that you may have, or current medications that you may be taking, could have an important interrelationship with the treatments you will receive. We thank you for answering the following questions accurately.

Reason for today's office visit: _____

Are you under a physician's care? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing Bisphosphonates? Yes No If yes, please explain: _____

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Any history of controlled substances? Yes No

Do you need to pre-medicate? Yes No If yes, please explain: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other No Known Allergies

Please list any other medication(s) you are taking: _____

Women: Are you Pregnant / Trying to get pregnant? Yes No

Taking oral contraceptives? Yes No

Nursing? Yes No

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

AIDS/HIV Positive Yes No
 Alzheimer's Disease Yes No
 Anaphylaxis Yes No
 Anemia Yes No
 Angina Yes No
 Arthritis/Gout Yes No
 Artificial Heart Valve Yes No
 Artificial Joint Yes No
 Asthma Yes No
 Bad Breath Yes No
 Bleeding Gums Yes No
 Blood Disease Yes No
 Blood Transfusion Yes No
 Breathing Problem Yes No
 Bruise Easily Yes No
 Cancer Yes No
 Chemotherapy Yes No
 Chest Pains Yes No
 Cold Sores Yes No
 Cong. Heart Disorder Yes No
 Convulsions Yes No

Cortisone Medicine Yes No
 Diabetes Yes No
 Drug Addiction Yes No
 Dry Mouth Yes No
 Easily Winded Yes No
 Emphysema Yes No
 Epilepsy or Seizures Yes No
 Excessive Bleeding Yes No
 Excessive Thirst Yes No
 Fainting Spells Yes No
 Frequent Cough Yes No
 Frequent Diarrhea Yes No
 Frequent Headaches Yes No
 Genital Herpes Yes No
 Glaucoma Yes No
 Grinding Teeth Yes No
 Hay Fever Yes No
 Heart Attack/Failure Yes No
 Heart Murmur Yes No
 Heart Pacemaker Yes No
 Heart Trouble/Disease Yes No

Hemophilia Yes No
 Hepatitis A Yes No
 Hepatitis B or C Yes No
 Herpes Yes No
 High Blood Pressure Yes No
 Hives or Rash Yes No
 Hypoglycemia Yes No
 Irregular Heartbeat Yes No
 Jaw Clicking Yes No
 Kidney Problems Yes No
 Leukemia Yes No
 Liver Disease Yes No
 Loose Teeth Yes No
 Low Blood Pressure Yes No
 Lung Disease Yes No
 Mitral Valve Prolapse Yes No
 Osteoporosis Yes No
 Pain in Jaw Joints Yes No
 Parathyroid Disease Yes No
 Periodontal Treatment Yes No
 Psychiatric Care Yes No

Radiation Treatments Yes No
 Recent Weight Loss Yes No
 Renal Dialysis Yes No
 Rheumatic Fever Yes No
 Rheumatism Yes No
 Scarlet Fever Yes No
 Shingles Yes No
 Sickle Cell Disease Yes No
 Sinus Trouble Yes No
 Smoking / Tobacco Yes No
 Stomach Problems Yes No
 Stroke Yes No
 Swelling of Limbs Yes No
 Teeth Sensitivity Yes No
 Thyroid Disease Yes No
 Tonsillitis Yes No
 Tuberculosis Yes No
 Tumors or Growths Yes No
 Ulcers Yes No
 Venereal Disease Yes No
 Yellow Jaundice Yes No

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE?

Yes No If yes, please explain: _____

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. I authorize Dr. Yolanda Cintron to use any image or video recording of me to diagnose, develop a treatment plan, for patient viewing / education and any form of marketing. 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 address, insurance info and medical status. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient's Signature, Parent or guardian

Date

Notice of Privacy Practices - August 1, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please Review It 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, and future physical, dental or mental health condition and related health care services.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you. This is different than the authorization and consent mentioned above. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed consent and a special written authorization that complies with the law governing HIV or substance abuse records.

Individual Rights

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. In order to do so, you must submit a written request to inspect and/or copy your health information. Your request may be denied in certain limited circumstances. However, if you are denied, you may ask that the denial be reviewed. We will comply with the outcome of the review.

You have the right to request a correction or change to your health information if you believe it is incorrect or incomplete. Your request must be in writing and include a reason to support the request. We may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

You have the right to request an accounting of disclosures.

This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing which states a time period no longer than six years and does not include dates before April 14, 2003. We may charge you for the costs of providing the list, either electronically or paper copy. However, you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to be assured that your information will be kept confidential. You may request that we communicate with you about medical matters in a certain way or at a certain location.

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to a paper copy of this notice. If you have agreed to receive it electronically, you are still entitled to a paper copy. You may ask us to give you a copy of this notice at any time by contacting the Privacy Officer, Office of the General Counsel.

Changes to This Notice We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date. You are entitled to a copy of the notice currently in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

For Further Information

Requests for further information about information covered in this notice may be directed towards the person who gave you the notice or our Privacy Officer, The International Center For Dental Excellence, 2021 E. Commercial Blvd. #208, Ft. Lauderdale, FL 33334 or by phone at (954) 938-4599.

The International Center For Dental Excellence – Dr. Yolanda Cintron D.M.D., P.A. - August 12, 2014.

I hereby acknowledge that I have received and read this Notice of Privacy Practices.

Patient's Signature

Date

Witness Signature

Date

Doctor's Signature

Date