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

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: ____

Who may we thank for referring you? ____

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

MEDICAL HISTORY

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 medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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?

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Dry Mouth	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Jaw Clicking	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Bad Breath	☐ Yes ☐ No	Fainting Spells	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No
Bleeding Gums	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Loose Teeth	☐ Yes ☐ No	Teeth Sensitivity	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Grinding Teeth	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cold Sores	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Periodontal Treatment	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cong. Heart Disorder	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Radiation Treatments	☐ 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 information 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**

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

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 1, 2013.

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**