CLAUDIA MINADEO-FOX D.D.S.

Health Inspired Dentistry
Whole Body Health & Wellness

Confidential Patient Information

Today's Date:

Patient's Name: First: | Middle: | Last: | Sex:

Parent's Name (if minor): | Date of Birth: | SS#: | Marital Status:

Street Address: | Home Phone: | Work Phone: | Cell Phone:

City: | State: | Zip: | Email:

Primary Insurance Policy Holder's Information

Name: | Date of Birth: | SS#: | Home Phone: | Work Phone:

Street Address: | City: | State: | Zip:

Employer: | Employer's Phone:

Insurance Company Name: | Phone #: | ID #: | Group #:

Secondary Insurance Policy Holder's Information

Name: | Date of Birth: | SS#: | Home Phone: | Work Phone:

Street Address: | City: | State: | Zip:

Employer: | Employer's Phone:

Insurance Company Name: | Phone #: | ID #: | Group #:

Physician Name: | Physician Phone:

Pharmacy: | Pharmacy Phone:

All About You

How would you like to receive appointment reminders? ☐ Email ☐ Phone Call ☐ Postal Mail ☐ Text Message (cell)

Are you interested in hearing about nutrition or health tips? Y ☐ N ☐

Email

As part of our whole body health and wellness, we offer complimentary upper body massages.

Are you interested in this service or other services we offer? Y ☐ N ☐

Phone

Financial Acknowledgment

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I assign directly to Claudia Minadeo-Fox D.D.S. Inc. any benefits paid by my insurance for services rendered. I accept full financial responsibility for all charges not covered by insurance.

I agree as a parent/guardian that I am responsible for all fees and services rendered for treatment of my minor/child.
(Divorced or separated spouses: The parent who brings the child in for treatment will be responsible for all fees at the time of service. We do not handle reimbursement for the other spouse.)

Signature: _____ **Date:** _____

(If under 18, Parent or Guardian Signature Required)

Comprehensive Medical and Dental History

In order to provide you with exceptional care, please take the time to provide us with detailed information about your oral and overall health. Science indicates many links between your systemic (bodily health) and oral health.

Medical History

How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

When was your last physician visit? _____ Reason: _____

Date of last physical examination? _____

Y N

☐ ☐ Has there been any problem with your general health within the past 5 years? (serious illness, hospitalization, surgery)
If yes, please describe: _____

Y N

☐ ☐ Does your physician require you to take any premedication before dental procedures?
If yes, please describe: _____

List All Medications you are taking including over the counter and vitamins:

_____

If female, please answer the following:

Y N

☐ ☐ Are you taking birth control pills?
☐ ☐ Are you pregnant? If Yes, # of weeks? _____
☐ ☐ Are you nursing?

Please answer the following:

Y N

☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP: _____ / _____ Heart Rate: _____

Height: _____
Weight: _____

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer-Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV + AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other:

_____
_____
_____

Y N

☐ ☐ Do you have any disease, condition or problem not listed that the doctor should know about or that you are currently being treated?
If yes, please describe: _____

Dental History

When was your last dental visit? _____ Reason: _____

Please describe the main motivation for your making your appointment today?

_____

How often do you routinely visit the dentist? ☐ 3months ☐ 4 months ☐ 6 months ☐ 12 months ☐ not routinely

How would you rate the overall condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How important is your dental health on a scale 1-10 (with 10 the healthiest)? _____

Please rate your smile 1-10 (with 10 the best) _____

Is there something you would you like to change about your smile? ☐ shape ☐ shade ☐ alignment ☐ bite (occlusion)

☐ replace old fillings or dental work ☐ other: _____

Have you ever…… Y N

☐ ☐ fainted in a dental office?
☐ ☐ had an allergic reaction?
☐ ☐ had abnormal bleeding?
☐ ☐ had any complications following dental treatment?
if yes, please describe: _____
☐ ☐ had periodontal (gum) treatment or surgery?
☐ ☐ had oral surgery (teeth removed)?
☐ ☐ had orthodontic treatment?
☐ ☐ had dental implants?
☐ ☐ had your teeth ground or bite adjusted?
☐ ☐ worn a bite plate or other appliance?
☐ ☐ had any pain or clicking in the jaw joint around your ear?
☐ ☐ had jaw soreness?

Do you presently … Y N

☐ ☐ have any teeth that ache?
☐ ☐ experience any sensitivity to ☐ cold ☐ hot ☐ pressure
Where? _____
☐ ☐ notice shifting or spaces between your teeth now where there was none before, are your teeth flaring, or are some of your teeth becoming loose?
☐ ☐ catch food between your teeth?
☐ ☐ have any: ☐ headaches ☐ neck pain
☐ ☐ grind your teeth or told that you do?
☐ ☐ mouth breathe while awake or asleep?
☐ ☐ hold foreign objects with your teeth such as: ☐ pencils ☐ pipe ☐ pins ☐ fingernails
☐ other: _____
☐ ☐ feel anxious or nervous about dental treatment?

Exposure To Hpv/Human Papilloma Virus

Risk factors for oral cancer in the past were linked to tobacco use and excessive alcohol.
Presently a root cause of new oral cancer is associated with HPV.

We now have oral DNA testing to assess your risk factor:

Y N

☐ ☐ Are you interested in more information?

Periodontal Health

The following risk factors increase the potential for periodontal (gum) disease.
Please check all risk factors you may have:

Y N
- ☐ ☐ Current tobacco use: What kind? _____ How much/day? _____
- ☐ ☐ Family history of gum disease (parents lost teeth at a young age)
- ☐ ☐ Experience episodes of bleeding gums
- ☐ ☐ Have a spouse or partner with gum disease (gum disease is transmissible & family members should be screened)
- ☐ ☐ Stress. Chronic stress affects the body's cortisol production and body's defense against inflammation
- ☐ ☐ Osteoporosis(bone density can contribute to loss of the supportive foundation of the teeth)
  If yes, have you taken any biophosphonates such as Fosomax, Actonel, Boniva, Zometa etc.)? Y ☐ N ☐
- ☐ ☐ Crowding teeth or orthodontic relapse
- ☐ ☐ Diabetes ☐ Type 1 ☐ Type 2 ☐ Borderline Diabetic
- ☐ ☐ Heart disease
- ☐ ☐ Autoimmune disease type: _____
- ☐ ☐ Organ transplant
- ☐ ☐ Chemo or radiation Date of last treatment? _____

Hormone Inbalance

Clinical signs of hormonal imbalance and stress, can be visualized as inflammation in certain areas of your mouth and gums.
STRESS
Current stress level on a scale of 1 to 10 (with 10 being the most stress)? _____

Do you have any of the following?

Y	N		Y	N		Y	N		Y	N	
☐	☐	depression	☐	☐	hair loss	☐	☐	mood swings	☐	☐	trouble sleeping
☐	☐	irritability	☐	☐	poor memory	☐	☐	trouble with thyroid	☐	☐	anxiety

Nutrition

A well balanced diet, weight control and lifestyle are all critical factors to optimizing your oral health.
Please provide us with detailed information so we can guide you to a healthier happier smile.

Y	N	Check all that apply to you:	Y	N	
☐	☐	find it hard to eat a balanced diet	☐	☐	drink less than 8 glasses of water daily
☐	☐	notice a sudden weight gain or loss	☐	☐	drink mostly bottled water
☐	☐	have an eating disorder (bulimia, anorexia)	☐	☐	should exercise more regularly
☐	☐	have sugar cravings	☐	☐	have had my vitamin D levels checked
☐	☐	feel bloated			

Acid reflux: A healthy mouth means maintaining a balanced PH environment. An unbalanced acidic environment will lead to gum disease and cavities. A large portion of the population has no obvious signs or symptoms of this condition but there are subtle signs of the problem in your mouth.

Y N
- ☐ ☐ I know I have acid reflux

I may have these risk factors:

Y	N		Y	N		Y	N	
☐	☐	acid reflux, heartburn or indigestion	☐	☐	excessive wear of teeth	☐	☐	stomach ulcer
☐	☐	burping or belching	☐	☐	sensitive teeth	☐	☐	sleep apnea
☐	☐	hernia	☐	☐	shiny or flat teeth	☐	☐	clearing of throat
☐	☐	dry cough	☐	☐	pregnancy	☐	☐	take tums often
☐	☐	recent new cavities						

Sleep Disorders

Sleep is critical in healthy living. Getting REM sleep is critical for your body to heal, process thoughts and emotions, and regenerate. Sleep Apnea is a complete process that needs treatment if experiencing. Sleep Apnea can contribute to cardiovascular issues and acidic oral environments.

Check all that apply:

Y	N		Y	N	
☐	☐	snore	☐	☐	have a CPAP machine and use it nightly
☐	☐	feel tired , fatigued or sleepy during the day	☐	☐	have a CPAP machine but cannot tolerate it
☐	☐	choke or gasp while sleeping	☐	☐	regularly use a dental protrusive device to assist with sleep apnea or snoring

Staff use:

☐ elongted uvula	☐ large tonsils	☐ class 2 occlusion	☐ Bruxism
☐ Narrow Airway	☐ Scalloped enlarged tongue	☐ Tori	☐ Recommend sleep evaluation

Medical and Dental History Acknowledgement

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctor at my next appointment.

Signature: _____ **Date:** _____

(If under 18, Parent or Guardian Signature Required)

Responsibility And Consent Statement

Patient Name: _____

I hereby authorize and request the performance of dental services for:
I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment.

Signature: _____ **Date:** _____

(If under 18, Parent or Guardian Signature Required)

Your Child's First Visit

What to expect on your child's visit: We invite parents into the room for the first exam in order to participate in the assessment and planning of your child's dental care and to foster trust in your child. For future visits, after trust and confidence have been established we ask that parents remain in the reception area. This enables your child to develop positive dental experiences on their own.

Parents' Signature: _____ **Date:** _____

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New Patient Interview and Building Relations

Our purpose in conducting this New Patient Interview is to learn more about you, our patient. Our dental team can then support you with all of the important information needed to make informed decisions regarding your overall health.

Patient's Name: First:	Middle:	Last:	Date of Visit:

What are your objectives regarding your dental health?

☐ Pain free ☐ Bright white smile ☐ Healthy gums ☐ Straighter teeth ☐ Keeping your natural teeth for a lifetime

☐ Handle the problem correctly the first time ☐ Fresh breath ☐ Other:

What dental problems have you had in the past?

Currently experiencing?

How do these problems affect you?

So that we may serve you personally and comfortably, which of the following are most important to you?

☐ On time from start to finish

☐ Ideal appointment: Time:

Day: ☐ Tues ☐ Wed ☐ Thurs

☐ A clear understanding of the problem and recommending solutions

☐ To know absolutely everything that is going on in your mouth, regardless of its severity

☐ To handle only your most pressing needs

☐ To be informed of how you can enhance your: ☐ Facial appearance ☐ The whiteness of your teeth ☐ Your overall health

☐ To be done with treatment sooner with longer appointments

☐ Multiple shorter appointments to complete treatment

☐ An aroma therapy warm moist towel after each visit to freshen up

☐ To be called after your visit to follow up

☐ An email to remind you of your appointment so that you may be prompt

☐ A reminder card for your oral wellness visit

We are a zero balance office. If there is an investment in your health, what method of payment is best for you?

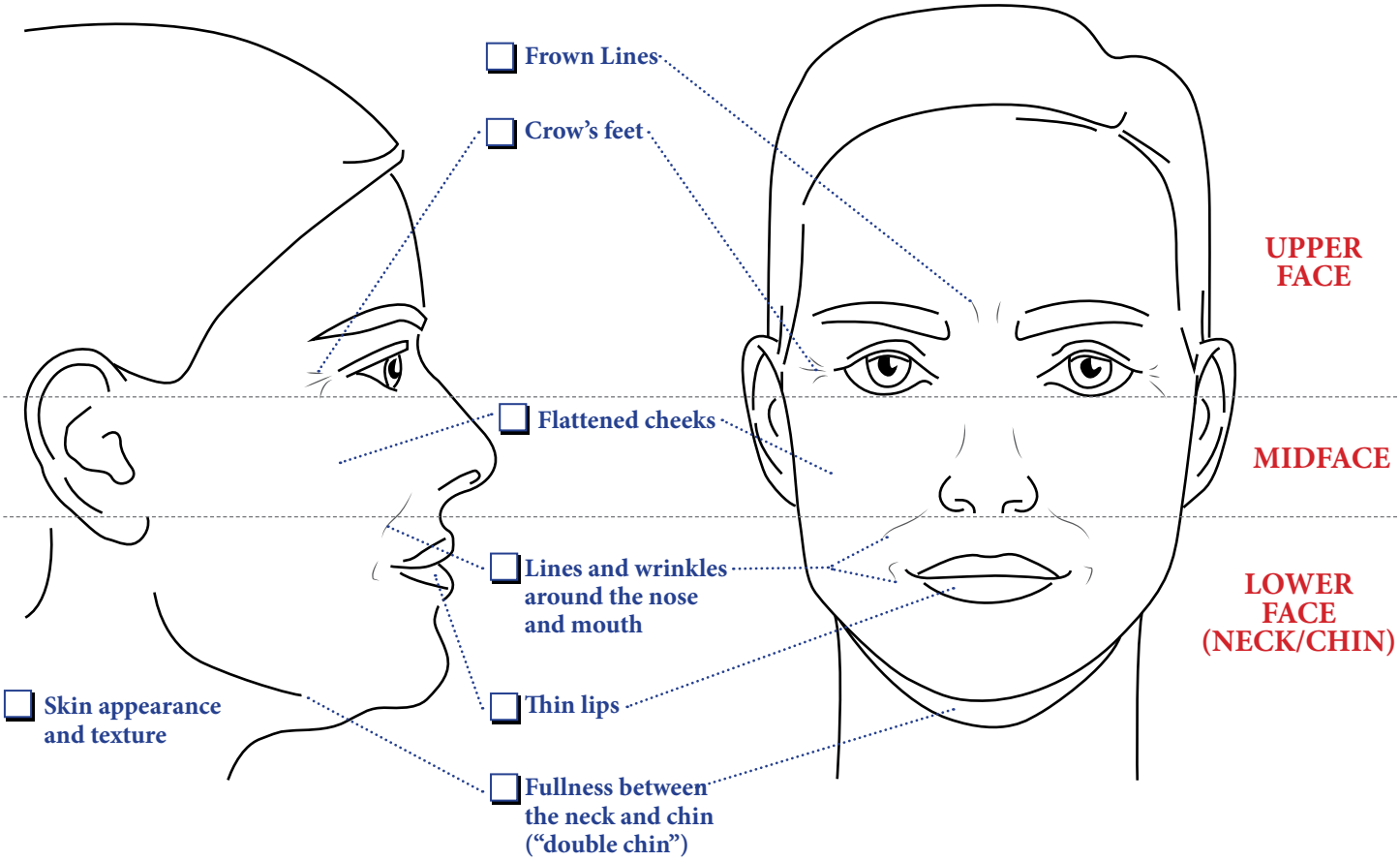
☐ Cash ☐ Check ☐ Credit Card ☐ Interest-free financing

FACIAL AESTHETIC SELF ASSESSMENT

At our Health Inspired Dental Office, we know there is more to a great smile... Therefore we offer Botox®, dermal fillers, and other facial aesthetic services that compliment your smile.

Name: _____ **Date:** _____

Select which areas of the face concern you on the diagram below.
By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please check below if you are interested in therapeutic uses of Botox® in dentistry:

- ☐ Temporomandibularjoint disorder (TMJ)
- ☐ Bruxism or grinding
- ☐ Headaches
- ☐ Gummy smile (high lip line)
- ☐ Black triangles or spaces between teeth
- ☐ Masseteric Hypertrophy (increased size of facial muscles)

CLAUDIA MINADEO-FOX D.D.S.

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Phone: 440-446-9417

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Whole Body Health & Wellness

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy policies, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/16/14, and will remain in effective until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information disclosed on this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications or healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclosure your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclosure your health information to you, as described in the Patients' Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of our best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you for each page, for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (email), you are entitled to receive this Notice in written form.

Questions and Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:

Relationship to Patient:

(If under 18, parent or guardian signature is required)

Signature: **Date:**

(If under 18, Parent or Guardian Signature Required)