FACIAL AESTHETIC and THERAPEUTIC MEDICAL HISTORY

In order to provide you with the most appropriate treatment, please complete the following questionarre.

PERSONAL INFORMATION

Client Name: **Today's Date:**

Date of Birth: **Age:** **Occupation:**

Home Address: **City:** **State:** **Zip:**

Home Phone: **Cell Phone:** **Email Address:**

What is the best number for you to receive a follow up call this evening?

Emergency Contact Name: **Emergency Phone:**

How were you referred to us?

MEDICAL HISTORY

Are you currently under the care of a physician? YES ☐ NO ◯

If yes, for what?

Do you have any of the following medical conditions? (Please mark YES or NO to all)

Y	N	Conditions	Y	N	Conditions
☐	◯	High Blood Pressure	☐	◯	Hormone imbalance
☐	◯	Heart Conditions	☐	◯	Any active infection
☐	◯	Blood Clotting Abnormalities	☐	◯	Are you pregnant or trying to get pregnant"
☐	◯	Diabetes	☐	◯	Are you using contraception?
☐	◯	Arthritis	☐	◯	Are you breastfeeding?
☐	◯	Cancer-Chemotherapy	☐	◯	Birth control pills
☐	◯	HIV + AIDS	☐	◯	Neurologic disease
☐	◯	Hepatitis A or B or C	☐	◯	Myasthenia Graves
☐	◯	Seizure Disorder	☐	◯	Lambert-Eaton Syndrome
☐	◯	Herpes	☐	◯	Parkinson's
☐	◯	Frequent cold sores	☐	◯	Multiple Sclerosis (MS)
☐	◯	Keloid scarring	☐	◯	Amuotrophic Lateral Sclerosis (ALS)
☐	◯	Skin lesions	☐	◯	Fainting problems
☐	◯	Skin disease	☐	◯	Pschiatric problems
☐	◯	Thyroid imbalance	☐	◯	Headaches or Migranes

Do you have any disease, disorder or problems not listed above that the doctor should know about or that you are currently being treated for? If YES, please describe. YES ☐ NO ◯

What oral prescription medications are you presently taking?

What antibiotics do you use to treat infections?

Are you presently taking any of the following medication or supplements listed below?

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	◯	Aspirin	☐	◯	Blood thinners	☐	◯	Hormones
☐	◯	Mood altering medication	☐	◯	Anti-depression medication	☐	◯	Vitamin E
☐	◯	Fish oil	☐	◯	Omega 3 fatty acids	☐	◯	Ginkgo biloba
☐	◯	Garlic	☐	◯	Ginger	☐	◯	Cayenne
☐	◯	Licorice	☐	◯	Flax seed oil	☐	◯	COQ10

Have you ever had an allergic reation to the following?

- ☐ Food
- ☐ Eggs
- ☐ Animal Protein
- ☐ Latex
- ☐ Aspirin
- ☐ Hydroquinone or skin bleaching agents
- ☐ Lidocaine (Anesthetic)
- ☐ Hydrocortisone

☐ **Any other Alleries? Please list:**

FACIAL HISTORY

What bothers you most about your facial appearance?

What are your expectations for today's visit?

Do you regularly sunbathe or use tanning salons? YES ☐ NO ○ **How often?**

What topical medications or creams are you currently using? ☐ **Retin-A** ☐ **other**

(please list):

Have you waxed, tweezed, bleached or used hair removal cream within the last week? YES ☐ NO ○

If yes please specify:

Have you ever had Botox or dermal fillers? YES ☐ NO ○ **If yes, when were you last treated:**

Any complications? YES ☐ NO ○ **If yes please specify:**

Have you taken any Aspirin, Ibuprofen, Motrin, Tylenol, fish oil, Vitamin D, blood thinners, or alcoholic beverages in the last 10 days? YES ☐ NO ○

If yes what?

FACIAL INJURY TRAUMA HISTORY

Is there any history of facial surgery? YES ☐ NO ○

Describe:

is there any recent history of trauma to the head or face? YES ☐ NO ○

Describe:

Any TMJ problems? YES ☐ NO ○

Describe:

BRILLIANT DISTINCTIONS

Are you currently enrolled in the Brilliant Distinctions Program? YES ☐ NO ○

If yes, please provide us with your member number:

If not, Brilliant Distinctions is a program that rewards you with savings on Allergen facial treatments including products like Botox,® Juvederm and SkinMedica Skin Care. Ask us for details on how to sign up.

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

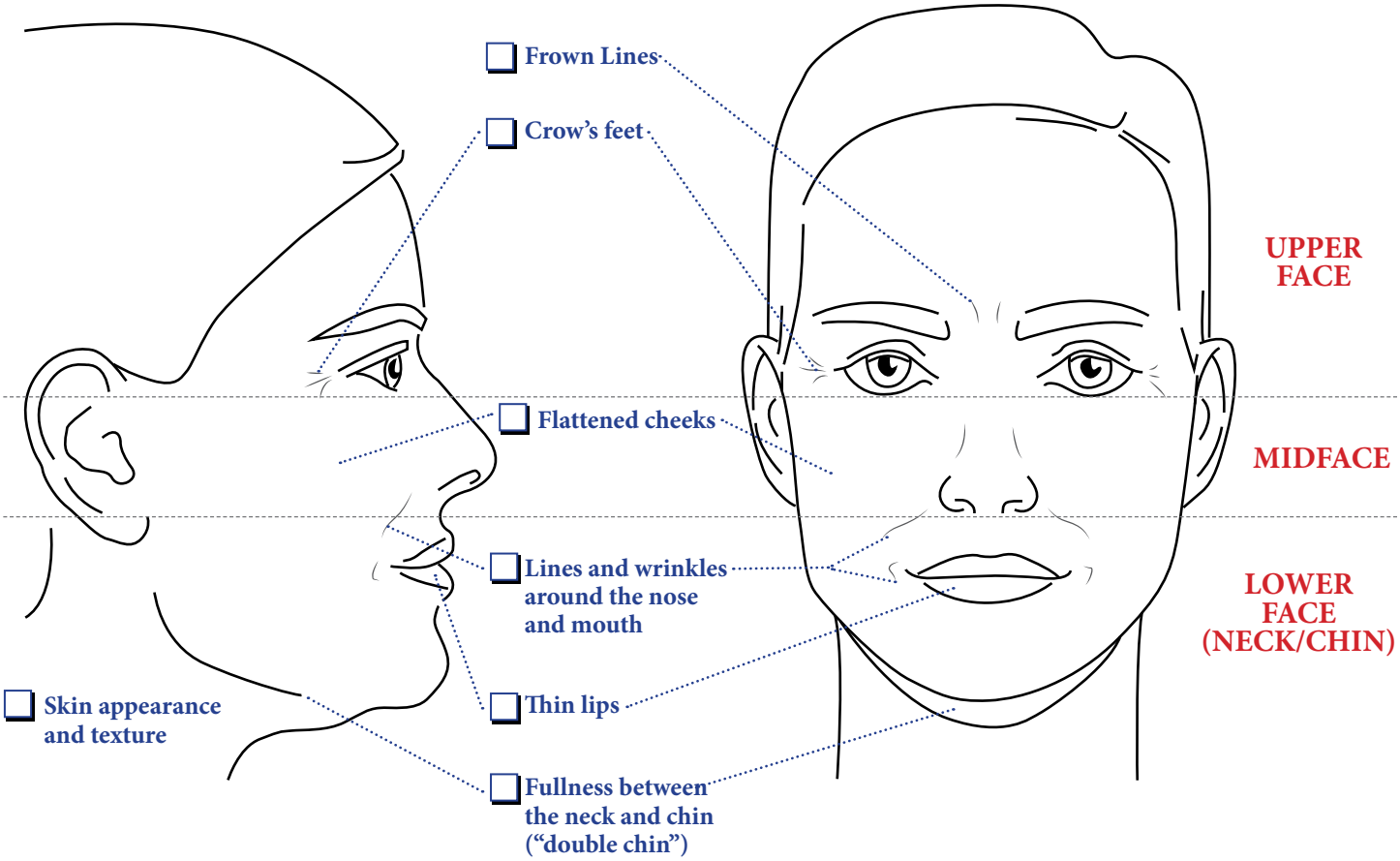
Signature: _____ **Date:**

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)

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Highland Heights, Ohio 44143
Phone: 440-446-9417

Health Inspired Dentistry
Whole Body Health & Wellness

INFORMED CONSENT FOR DERMAL FILLER TREATMENT

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

Street Address:	Phone:

City:	State:	Zip:

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT
Treatment with dermal fillers (such as Juvederm, Restylane, Radiesse and others) can smooth out facial folds and wrinkles, add volume to the lips, and contour facial features that have lost their volume and fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. These dermal fillers are injected under the skin with a very fine needle. This produces natural appearing volume under wrinkles and folds which are lifted up and smoothed out. The results can often be seen immediately.

Initial:

RISKS AND COMPLICATIONS
Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, bruising, and discoloration; 2) Post treatment infection associated with any transcutaneous injection; 3) Allergic reaction; 4) Reactivation of herpes (cold sores); 5) reaction and safety in those patients with keloid formation is unknown, 6) Lumpiness, visible yellow or white patches; or migration of the filler may occur; 7) Granuloma formation; 8) Localized necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

Initial:

PREGNANCY AND ALLERGIES
I am not aware that I am pregnant. I am not trying to get pregnant. I am not lactating (nursing). I do not have or have not had any major illnesses which would prohibit me from receiving dermal fillers. I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to lidocaine.

Initial:

ALTERNATIVE PROCEDURES
Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

Initial:

PAYMENT
I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

Initial:

I understand that I have the right to discontinue treatment at any time.

Initial:

INFORMED CONSENT FOR DERMAL FILLER TREATMENT

(continued)

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold Dr. Claudia Minadeo-Fox, D.D.S. harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Initial:

RESULTS

Dermal fillers have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. Its effect can last up to 6 months and in some cases 1 year. Most patients are pleased with the results of dermal fillers use. However, like any esthetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek. The dermal filler procedure is temporary and additional treatments will be required periodically, generally within 4-6 months, involving additional injections for the effect to continue. I am aware that follow-up treatments will be needed to maintain the full effects. I am aware the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue conditions, my general health and life style conditions, and sun exposure. The correction, depending on these factors, may last up to 6 months and in some cases shorter and some cases longer. I have been instructed in and understand the post-treatment instructions

Initial:

I understand this is an elective procedure and I hereby voluntarily consent to treatment with dermal fillers for facial rejuvenation, lip enhancement, establish proper lip and smile lines, and replacing facial volume. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Health History Completed? **Yes** ☐ **No** ☐ **Date:** **Doctor Initial:** _____

Dental / Head and Neck Examination Completed? **Yes** ☐ **No** ☐ **Date:** **Doctor Initial:** _____

Patient Name: (Print) **Patient Signature:** **Date:**

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print) **Doctor Signature** _____ **Date** _____

Dr. Claudia Minadeo- Fox

Dr. Claudia Minadeo-Fox, D.D.S.
Health Inspired Dentistry
Dermal Fillers PRE - TREATMENT INSTRUCTIONS

A few simple guidelines before your treatment can make a difference between a good result and a fantastic one.

- Patient should be in good health. A full medical and dental history is necessary on all patients for optimal results.

- Eat a small meal/snack before the injection. Some people can become light headed during an injection because the individual has not eaten to maintain a normal blood glucose level.

- If you develop a cold sore, blemish, or rash, etc. prior to your appointment in the injection area, your appointment should be rescheduled. Let us know if you are prone to cold sores – a pre-operative medication may help prevent cold sores after treatment.

- Avoid alcoholic beverages at least 24 hours prior to treatment. Alcohol may thin the blood which will increase the risk of bruising.

- AVOID: Anti-inflammatory and blood thinning medications ideally for 2 weeks prior to treatment (for example: Aspirin, Motrin, Aleve, Advil, Ginkgo Biloba, St. John's Wart, CoQ10, Garlic, Flax Oil, Cod Liver Oil, Fish Oil, Vitamin A, Vitamin E). which can increase your chance of bruising and swelling after the procedure. If you have a body ache or headache it is ok to take Tylenol.

- Discontinue Retin-A two (2) days before and two (2) days after treatment.

- Schedule your appointment 2 weeks or more prior to a special event or vacation should bruising occur.

Dr. Claudia Minadeo-Fox, D.D.S.
Health Inspired Dentistry
Dermal Fillers POST TREATMENT INSTRUCTIONS

- DO NOT: touch, press, rub or manipulate the implanted areas for the rest of the day after treatment. Avoid kissing, puckering and sucking movements for the rest of the day as these motor movements can undesirably displace the implanted dermal filler material. Manipulation can also cause irritation, sores, scaring and other possible problems.

- AVOID: Alcoholic beverages at least 24 to 48 hours after treatment. Anti-inflammatory and blood thinning medications ideally for 24-48 hours after treatment (for example: Aspirin, Motrin, Ginkgo Biloba, Garlic, Flax Oil, Cod Liver Oil, Fish Oil, Vitamin A, Vitamin E). This will reduce the incidence of bruising. If you have a body ache or headache it is ok to take Tylenol.

- AVOID: Vigorous exercise, sun and heat exposure for 3 days after treatment. Avoid sleeping on your face, micro dermal abrasion, facials or peels for 3-5 days, laser or light treatments for 2-4 weeks.

- DISCONTINUE: Retin-A for 2 days following treatment.

- One side of your face may heal faster than the other side.

- You must wait 2 weeks before any enhancements.

- Please report any redness, blisters, itching or unusual pain immediately if it occurs after treatment.

- Arnica tablets or cream maybe used to minimize bruising and speed up healing. Arnica Montana is a herbal over the counter medication that is proven through research to help healing. You can purchase these tablets or cream at a drug store or vitamin shop.

- It is best to wear no makeup or lipstick until the next day. Earlier use can increase the chance of infection at the injection sites.

- You can expect some bruising and swelling around the areas that were injected. Lightly apply, if needed, ice for the first hour after treatment for ten minutes on and ten minutes off.

I certify that I have been counseled in post-treatment instructions and have been given written instructions as well.

Patient Signature: **Date:**

CLAUDIA MINADEO-FOX D.D.S.

6151 Wilson Mills Road, Suite 300
Highland Heights, Ohio 44143
Phone: 440-446-9417

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)