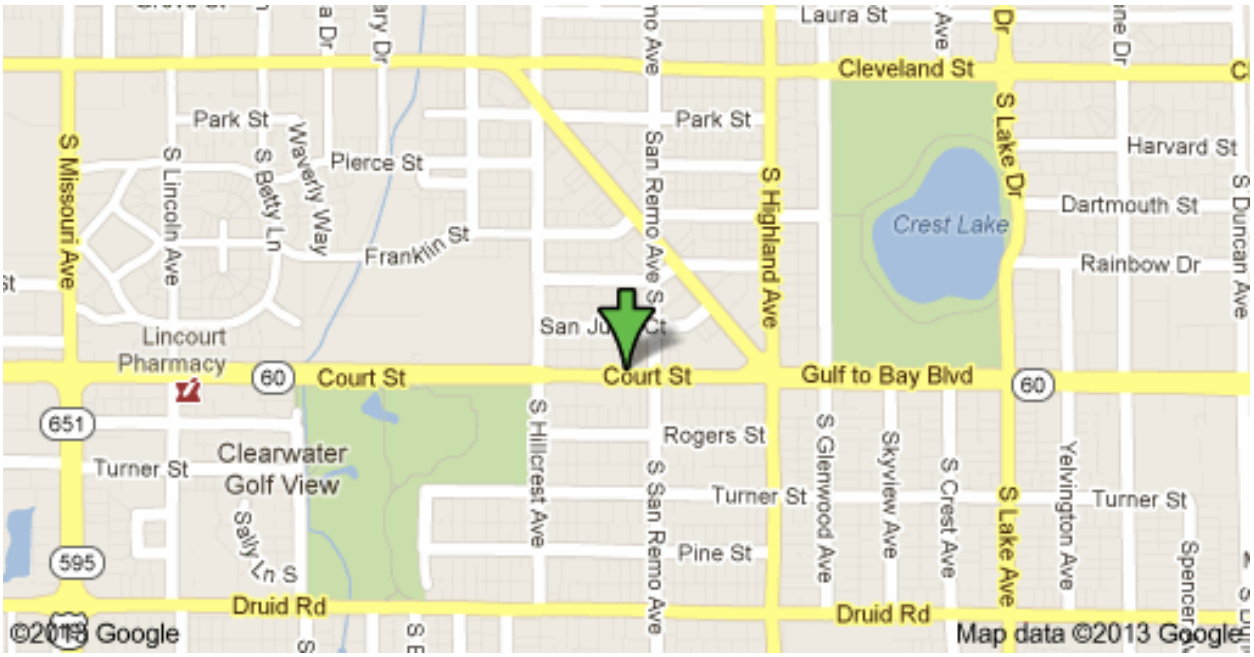
Dr. Paul A. Guidi

Dr. Paul A. Guidi is originally from Boston, Massachusetts and has been in private practice at his Clearwater, Florida office since 1988. He is a graduate of the University of South Florida and received his Doctorate of Dental Medicine from the University of Florida College of Dentistry.

Dr. Guidi is a Clinical Assistant Professor of Prosthodontics at the University of Florida College of Dentistry teaching occlusion at both the undergraduate and graduate levels. He is also a visiting faculty member of the Spear Institute of Advanced Dental Education. He has lectured nationally and internationally on topics of occlusion and the temporomandibular joint issues.

Dr. Guidi is a Fellow of the Academy of General Dentistry and holds memberships in several state and national dental societies.



Please visit our website to learn more about our dental practice prior to your appointment.

www.guididental.com

1438 Court Street • Clearwater, Florida 33756
Tel. (727) 447-3144 • Fax (727) 446-3844

I would like to thank you and welcome you to our office. I will start by sharing with you our guiding beliefs for our patients.

Our philosophy is to help each patient achieve the highest level of dental health that is appropriate for them, recognizing that not all patients have the same dental needs or desires. With that in mind, we would ask you to identify how you would like to be seen on our office ***by checking which of the 3 levels of care seem appropriate for you at this time***. Please understand that it is not uncommon for patients to choose a different path after they have experienced our office, but this serves as a starting point.

Level 1: Reactive Care. Patients at this level are generally only interested in solving more urgent problems. A comprehensive examination or long term planning are not priorities at this time.

Level 2: Proactive Care. Patients who choose this level of care do want a comprehensive examination and want to be involved in the prevention of present and future disease. However, they typically choose repair solutions that are not long term in nature.

Level 3: Regenerative Care. Patients at this level have a high value for their dental health and appearance. They desire a comprehensive examination and wish to be informed of all findings as well as the potential consequences of each problem. Ultimately, they want to be involved in creating a long-term master plan for their dental health, which includes choosing the longest lasting solution to their problems.

We hope that these different levels make sense to you. As we stated before, it is not uncommon for patients to change levels after beginning treatment with us. We look forward to seeing you and helping you achieve the level of dental care most appropriate for you.

Sincerely,

Dr. Guidi and staff

Paul A. Guidi, DMD, PA
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Clearwater, FL 33756
(727)447-3144
pagdmd@aol.com

CONFIDENTIAL 1

PERSONAL INFORMATION

Full Name_____ Today's Date_____
Mr. Mrs. Ms. Rev. Dr.

I prefer to be addressed as_____ Birthdate_____

Whom may we thank for referring you to our practice?_____

Address_____ Home Phone_____

Address_____ Work Phone_____

City_____ State_____ Zip_____ Cell Phone_____

E-mail address_____

Preferred contact: ☐ E-mail ☐ Home Phone ☐ Work Phone ☐ Cell Phone Best time to call_____

Employer_____ Occupation_____

Spouse / Partner_____ Cell Phone_____

Additional Emergency contact_____ Phone_____

Last dental visit_____ with Dr._____

Why have you made this appointment?_____

PLEASE SELECT ONE BOX ON EACH LINE

☐ My mouth is very comfortable ☐ My mouth is moderately comfortable ☐ My mouth is uncomfortable

☐ My smile is excellent ☐ I would like to change my smile ☐ I am unconcerned about my smile

☐ I will do whatever I must to keep my teeth ☐ I want to keep my teeth but only within a certain budget of time and money

☐ I've done the dentistry recommended to me ☐ I've NOT done dentistry recommended to me ☐ Never been recommended

MY DENTAL HEALTH IS ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DENTAL INSURANCE – ***PRIMARY CARRIER***

Insurance Company_____ Group No._____

Employer Name_____

Insured's Name_____ DOB_____

Relationship to Patient_____ Insured's I.D. No._____ Insured's SSN_____

Account name preference: ☐ Self ☐ Spouse
Payment preference: ☐ Check ☐ Credit card (Visa, MC, AMEX)

Last Minute cancellations are a lose-lose situation for everyone. Your oral care will be delayed and we lose valuable treatment time that could go to another patient.

Please allow us the courtesy of a 72 hour notice if you will be unable to keep the appointment time that you have reserved at our office.

Signature:_____

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Guidi or a designated staff member to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental condition. I understand that these models, x-rays and photographs may be used for educational purposes.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature_____Date_____Witness_____

Parent/Responsible Party's Signature_____Relationship to Patient_____

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CONFIDENTIAL 2

Physician _____ Phone _____

How would you assess your general health ❑Good ❑Fair ❑Poor Last physical _____

Have you been hospitalized in the last 3 years? ❑Yes ❑No _____

List medications you take - please include prescription and over-the-counter (Continue on other side if needed)

_____ _____ _____

_____ _____ _____

Do you now have or have you ever had the following?

☐ YES	☐ NO	Severe or Frequent Headaches	☐ YES	☐ NO	Hemophilia
☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO	Liver Disease
☐ YES	☐ NO	Heart Attack	☐ YES	☐ NO	Bruise Easily
☐ YES	☐ NO	Heart Murmur	☐ YES	☐ NO	Neurological Disorders
☐ YES	☐ NO	Angina / Chest Pain	☐ YES	☐ NO	Kidney Disease
☐ YES	☐ NO	Shortness of Breath	☐ YES	☐ NO	Cancer
☐ YES	☐ NO	Asthma	☐ YES	☐ NO	Chemotherapy
☐ YES	☐ NO	Emphysema	☐ YES	☐ NO	Radiation Treatment
☐ YES	☐ NO	Scarlet Fever	☐ YES	☐ NO	HIV / Aids
☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO	Shingles
☐ YES	☐ NO	Heart Surgery	☐ YES	☐ NO	Cold Sores / Fever Blisters
☐ YES	☐ NO	Pacemaker	☐ YES	☐ NO	Diabetes
☐ YES	☐ NO	Mitral Valve Prolapse	☐ YES	☐ NO	Tuberculosis
☐ YES	☐ NO	Congestive Heart Failure	☐ YES	☐ NO	Arthritis
☐ YES	☐ NO	Swelling of the Ankles	☐ YES	☐ NO	Artificial Joints
☐ YES	☐ NO	Hardening of the Arteries	☐ YES	☐ NO	Artificial Valve
☐ YES	☐ NO	Abnormal Bleeding	☐ YES	☐ NO	Sinus Trouble
☐ YES	☐ NO	Frequent Nose Bleeds	☐ YES	☐ NO	Epilepsy / Seizure
☐ YES	☐ NO	Blood Transfusion	☐ YES	☐ NO	Psychiatric Problems
☐ YES	☐ NO	Fainting	☐ YES	☐ NO	Depression
☐ YES	☐ NO	Stroke	☐ YES	☐ NO	Ulcers
☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO	Colitis
☐ YES	☐ NO	Cortisone Medication	☐ YES	☐ NO	Anemia
☐ YES	☐ NO	Swollen Ankles	☐ YES	☐ NO	Veneral Disease
☐ YES	☐ NO	Thyroid Problems	☐ YES	☐ NO	Glaucoma
☐ YES	☐ NO	Latex Sensitivity	☐ YES	☐ NO	Drug / Alcohol Dependence

_____

_____

_____

_____

CONFIDENTIAL 3

Have you ever had an allergic reaction to medication? Y N

If yes, please list:_____

Do you smoke? Y N Chew Tobacco? Y N _____

WOMEN: Are you taking birth control pills? Y N

Are you pregnant? Y N

If pregnant, are you currently nursing? Y N

Date of last dental visit?_____ Reason_____

How often do you get your teeth cleaned?_____

Are your teeth sensitive to hot and cold? Y N _____

Are any of your teeth sensitive to biting pressure? Y N _____

Has your bite recently changed? Y N Do you have any loose teeth? Y N_____

Do your gums hurt or bleed? Y N _____

Does food tend to get caught between your teeth? Y N _____

Do you grind your teeth at night? Y N Do you grind your teeth during the day? Y N _____

Do you have tired jaws in the morning? Y N _____

Do your jaws ever pop or click? Y N _____

Do you have difficulty chewing? Y N _____

Have you ever had Orthodontic Treatment? Y N _____

Have you ever had Oral Surgery? Y N _____

Have you ever had Periodontal Treatment? Y N _____

Do you wear a bite guard at night? Y N _____

Signature_____ Date_____

SMILE EVALUATION

To aid in our diagnosis and treatment of your esthetic concerns, please take a moment and answer the following questions. Please circle your answer. If you are completely satisfied with the appearance of your teeth and smile, there is no need to fill out this form.

1) Do you dislike the color of your teeth? YES NO
2) Do you have spaces between your teeth that bother you? YES NO
3) Do you have chips or uneven edges on your teeth? YES NO
4) Do you feel your teeth are too long or too short? YES NO
5) Do you have dark fillings that show when you speak or smile? YES NO
6) Do your gums show too much when you smile? YES NO
7) Are you teeth too crowded or crooked? YES NO
8) Do you have existing crowns or dental work you consider "ugly"? YES NO
9) Are you self-conscious of your teeth or smile? YES NO
10) Has anyone (friend, family member, etc.) ever suggested that you do something about your teeth or smile? YES NO
11) Do you avoid smiling when you have your picture taken? YES NO
12) Would you like to improve your existing smile? YES NO
13) Do you wish you had a new smile? YES NO

What concerns do you have regarding dental treatment to improve your smile?

1) fear of treatment 2) time involved in treatment 3) financial concerns
4) distance to office 5) not understanding treatment 6) embarrassment 7) other

Thank You

INITIAL PATIENT SLEEP SCREENING

My studies into night-time bruxism have also introduced me to some of the leading research into sleep disturbances. I have found the negative health issues associated with poor sleep, snoring and apnea so compelling that I am now including questions concerning sleep health into my standard health protocol. Please complete the following section so that we may provide you with the best possible care.

Patient Name (Print) _____

Height _____ inches Weight _____ lbs.
Age _____
Male/Female
BMI _____ (we will calculate)
Collar size of shirt: S, M, L, XL, or _____ inches
Neck circumference* _____ inches

1. Snoring
   Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   Yes / No

2. Tired
   Do you often feel tired, fatigued, or sleepy during daytime?
   Yes / No

3. Observed
   Has anyone observed you stop breathing during your sleep?
   Yes / No

4. Blood pressure
   Do you have or are you being treated for high blood pressure?
   Yes / No

5. BMI
   BMI more than 35 kg/m2?
   Yes / No

6. Age
   Age over 50 yrs. old?
   Yes / No

7. Neck circumference
   Neck circumference greater than 17 inches?
   Yes / No

8. Gender
   Gender male?
   Yes / No

High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

Paul A. Guidi, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____