

TRI DENTAL
352-326-3368
HEALTH HISTORY

Patient Name _____ Spouse Name _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Phone numbers: Home: _____ Work: _____ Cell: _____

Email: _____ Marital Status: Married _____ Single _____ Divorced _____ Other _____

Male _____ Female _____ Date of Birth _____ Age _____ Social Security # (for insurance purposes only) _____

HOW CAN WE HELP YOU TODAY? _____

ARE YOU A SEASONAL RESIDENT? _____ YES _____ NO

How did you learn about our office: *(Please check one)*

Friend/ Relative _____ Tri Dental Website _____ Social Media _____
 Roadside Sign _____ Daily Commercial _____ Internet _____ Other _____

Date of last health care exam: _____ Date of last Dental Exam: _____ Last Dental Cleaning: _____

Name, location, phone number for Preferred **Pharmacy**: _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Artificial heart valve	No	Yes	Heart Attack (When)	No	Yes
History of infective endocarditis	No	Yes	Heart Bypass (When)	No	Yes
Congenital heart conditions (birth defects): repaired or incompletely repaired cyanotic disease, prosthetic repair, remaining defect After repair	No	Yes	High or Low blood pressure (circle)	No	Yes
			Heart Pacemaker	No	Yes
			Heart Stent (When)	No	Yes
			Stroke (When)	No	Yes
Cardiac transplant with heart valve problem	No	Yes	Heart Murmur/ Mitral Valve Prolapse	No	Yes
Treatment for Drug Addition	No	Yes	Treated for Anxiety	No	Yes
Treated for Chronic Pain Management	No	Yes	Treated for Depression	No	Yes
History of recreational drug use (Confidential)	No	Yes	Treated for Psychosis	No	Yes
Temporomandibular Joint(TMJ) problems	No	Yes	Treated for Hyperactivity	No	Yes
Asthma	No	Yes	Leukemia	No	Yes
Diabetes type 1 or 11	No	Yes	Joint Replacements When? What kind?	No	Yes
Hepatitis, Any Form	No	Yes	Cancer What Type	No	Yes
Liver disease (including Jaundice)	No	Yes	Slow-Healing Mouth Sores	No	Yes
Kidney disease	No	Yes	Abnormal Bleeding from a cut	No	Yes
Anemia (blood disease)	No	Yes	Glaucoma	No	Yes
Emphysema or other Respiratory Illnesses	No	Yes	Sinus Trouble	No	Yes
Seizures/Epilepsy	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Thyroid gland problems	No	Yes
Sexually Transmitted Diseases	No	Yes	Recurrent Illnesses	No	Yes
Alzheimer's/Dementia	No	Yes	Bone Disorders/Bone loss	No	Yes
G.E.R.D, Acid Reflux or Ulcers	No	Yes	Radiation or Chemotherapy (circle)	No	Yes
Dialysis	No	Yes	Low Blood Sugar	No	Yes

Are you taking any of these medications?

Recommended Antibiotics before Dental Treatment	No	Yes	Medications for Acid Reflux	No	Yes
Antacids?	No	Yes	Herbal Supplements?	No	Yes
Blood thinners? (Warfarin, Coumadin, Plavix)	No	Yes	Are you taking Aspirin? What mg?	No	Yes

Please list any **medications or supplements** you are currently taking?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Any surgeries and/or hospitalizations? Yes No

Please list: _____

Are you currently receiving medical care? No Yes: If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

- 1. _____ 2. _____
- 3. _____ 4. _____

Women: Are you pregnant?

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you taking birth control pills? No Yes

Abnormal Blood Pressure? (Please circle)

If yes, what is it usually? S _____ /D _____ No Yes

Are you Allergic or have you had a reaction to any of the following. Please circle and/or specify:

- a. Local Anesthetics _____ No Yes
- b. Penicillin or other antibiotics _____ No Yes
- c. Aspirin _____ No Yes
- d. Codeine, valium or other sedatives _____ No Yes
- e. Sulfa allergy _____ No Yes
- f. Latex allergy _____ No Yes
- g. Other _____

Are you a smoker?

If so, how much do you smoke per day? _____ No Yes

Do you wish to speak to the Doctor privately about anything? No Yes

Average Weight: _____

Diet: Restricted Diet: _____

How many meals a day? _____

Food Allergies: _____

Sugar in your diet: None Slight Moderate High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should the office need additional information, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health and medication.

Patient (Print Name)

Patient Signature

Date

Dentist (Print Name)

Dentist Signature

Date

Tri Dental

15923 US HWY 441

Eustis, FL 32726

Bisphosphonate Drugs

Despite the widespread use of bisphosphonates and their unequivocal efficacy for the treatment of various disease states, osteonecrosis of the jaw remains one of the most feared complications associated with their use, especially after surgical procedures. Current evidence, however, suggests that there is also a relationship between occurrence of osteonecrosis of the jaw and use of other cases of pharmacotherapies namely RANKL inhibitors as well as angiogenesis inhibitors. Although these drugs have different mechanisms of action than bisphosphonates, they all seem to interfere with the bone remodeling process i.e. Alter the balance between bone resorption and bone formation which may be the most plausible explanation for pathogenesis of osteonecrosis of the jaw.

Have you ever been treated with any of the following? Please circle

Brand Name (Generic Name)

Zometa, Raclast (Zoladronate)

Fosamax, Binosto, Fosamax plus D (Alendronate)

Aredia IV (Pamidronate)

Xgeva or Prolia shots (Denosumab)

Actonel, Atelvia (Risedronate)

Boniva (Ibandronate)

Avastin (Bevacizumab)

Sutuent (Sunitnib)

Nexavar (Sorafenib)

Zortrees, Afinitor or Afinitor Disperz (Everolimus)

Bonefos, Clasteon or Loron (Clodronate)

Didronel (Etidonate)

Torieel (Temsirolimus)

Votrient (Pazopanib)

Inlyta (Axitinib)

Skelid (Tildronate)

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How long have you been taking this medication? _____

If you have stopped, how long ago? _____

- I have **NEVER** taken any of the above medications. (Please Initial) _____

Patient Signature and date

Dentist Signature and date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES / USE AND DISCLOSURE FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Printed Name of Patient	Legal Relationship to the Patient (If required)

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone _____
2. Name _____ Relationship _____ Phone _____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ I decline to receive communications via text.

_____ I decline to receive communications via email.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature _____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.