TRI DENTAL

352-589-6067

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 ________ Internet ________ Google ________ Other; Please explain ________________

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/ ADHD	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/Wet Macular Generation	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	Prescribed medications for Acid Reflux	No	Yes
Over the Counter 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?** No Yes

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

Breast Augmentation?

Abnormal Blood Pressure? (Please circle) No Yes

If yes, what is it usually? S_______ /D_______

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? No Yes

If so, how much do you smoke per day?____________________

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

Average Weight: ____________

Diet: Restricted Diet: ______________________________

Sugar in your diet: O None O Slight O Moderate O 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 Bisphosphonate 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 the other cases of pharmacotherapies namely RANKL inhibitors as well as angiogenesis inhibitors. Although these drugs have different mechanisms of action than bisphosphonates, the 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 for osteonecrosis of the jaw.

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

Brand Name (Generic Name)

- Zometa, Reclast (Zolandronate)
- Aredia IV (Pamidronate)
- Actonel, Atelvia (Risedronate)
- Avastin (Bevacizumab)
- Nexavar (Sorafenib)
- Didronel (Etidronate)
- Votrient (Pazopanib)
- Skelid (Tildronate)
- anti-angiogenic agent (ranibizumab)
- Evenity (Romosozumab)
- Fosamax, Binosto, Fosamax plus D (Alendronate)
- Xgeva or Prolia shots (Denosumab)
- Boniva (Ibandronate)
- Sutuent (Sunitnib)
- Clasteon or Loron (Clodronate)
- Torieel (Temsirolimus)
- Inlyta (Axitinib)
- Eylea (Aflibercept)
- Zortrees, Afinitor, or Afinitor Disperz (Everolimus)

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

____

Doctor 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.