DR. YULIA PATERSON
DDS, NMD, IBDM

PEDIATRIC INTAKE FORM

CONGRATULATIONS!
You made the right choice for your child's dental health! Please fill out the following intake form to allow us to learn more about your child. Everything you share is confidential and will be used for diagnostic and educational purposes. We appreciate you trusting Link Dental Health with the health of your child.

Name: _____
Last Name First Name MI Preferred Name

DOB: _____ Gender: ☐ M ☐ F What school does the child attend? _____

Address: _____
Address City State Zip Code

Parent/Guardian Name: _____

Phone #: _____ Cell #: _____ Email: _____

Emergency Contact: _____
Name Relationship Contact Phone #

How may we contact you? ☐ Phone Call ☐ Text ☐ Email If calling, is it ok to leave a message? ☐ Y ☐ N
(Check all that apply)

How did you hear about us? _____

INSURANCE INFORMATION

☐ No Insurance ☐ Insurance through Parent/Guardian's Employer ☐ Self Purchased Policy

Insurance Policy 1

Your relationship to the subscriber: ☐ Dependent/Child ☐ Other _____

Subscriber Name: _____ Subscriber DOB: _____

Insurance Company: _____ Employer/Group Name: _____

Subscriber ID: _____ Group #: _____ Ins Phone #: _____

Insurance Policy 2

Your relationship to the subscriber: ☐ Dependent/Child ☐ Other _____

Subscriber Name: _____ Subscriber DOB: _____

Insurance Company: _____ Employer/Group Name: _____

Subscriber ID: _____ Group #: _____ Ins Phone #: _____

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MEDICAL / DENTAL HISTORY

Patient Name: _____

Name of Pediatrician: _____

Place of birth: ☐ Hospital ☐ Home Birth ☐ Birthing Center ☐ Other_____

Location of birth: _____ Mode of Delivery: ☐ Vaginal ☐ C-Section
City State

DURING PREGNANCY (Check if Yes)

- ☐ Antibiotics
- ☐ Trauma
- ☐ Illness
- ☐ Vitamins
- ☐ Other Medications

CHILD HABITS (Check if Yes)

- ☐ Sucking finger / thumb / lip / pacifier
- ☐ Nail Biting
- ☐ Speech Delay
- ☐ Snoring
- ☐ Teeth Grinding
- ☐ Wetting bed after 4 years of age
- ☐ Tossing and turning during sleep
- ☐ Nightmares
- ☐ Sleepwalking
- ☐ Mouth Breathing
- ☐ Bottle feeding to sleep
- ☐ Sippy Cup

Does the child have a daily <u>ORAL HYGIENE</u> routine?

- ☐ Brushing
- ☐ Flossing
- ☐ Nasal Hygiene

NUTRITION as a baby/infant (Check if Yes)

- ☐ Breast Milk
- ☐ Formula
- ☐ Spitting Up
- ☐ Drooling
- ☐ Reflux
- ☐ Mouth Breathing
- ☐ Constant Night Feedings
- ☐ Food Sensitivities / Allergies

Did the child have trouble breast or bottle feeding? ☐ Yes ☐ No

At what age did you introduce solid foods? _____

What is your child's favorite food / snack? _____

MEDICAL HISTORY

Has the child been diagnosed with any condition / disease? _____

_____

What medications does the child take?_____

_____

What vitamins does the child take? _____

_____

Does the child have a history of frequent ear infections? _____

_____

Asthma? _____

Has the child seen an ENT (ear/nose/throat) specialist in the past? _____

Does the child have occasional cold sores on lips or inside the mouth? _____

Other Surgeries/Procedures: _____

Does the child have a daily bowel movement? _____

Is the child seeing any specialty/wellness practitioners? (Chiropractor, myofunctional therapist, speech pathologist, etc.) _____

CHILD'S VACCINATION SCHEDULE (Check one)

- ☐ CDC recommended schedule
- ☐ Alternative (delayed) schedule
- ☐ Child never had vaccines

DENTAL HISTORY

Is this the child's first visit to the dentist? _____

If not, when was the last dental visit? _____

Did the child have X-rays taken in the past? _____

Did the child have dental caries (cavities) in the past? _____

Did the child have teeth extractions in the past? _____

Did the child have local anesthesia? _____

Did the child have conscious sedation or general anesthesia? _____

How did the child do/cope with past dental treatment? _____

Does the child participate in sports/activities? _____

PARENTS (Check one)

- ☐ Unmarried
- ☐ Married
- ☐ Separated
- ☐ Divorced

HOUSEHOLD

List Siblings and their ages: _____

_____

Pets in the household: _____

Your relationship to child: _____

Who does the child live with? _____

Does anyone smoke in the house? _____

Mother's profession: _____

Father's profession: _____

Are both biological parents raising the child? _____

What are you most concerned about with regards to your child's dental health?

_____

_____

Any additional comments:

_____

_____

We would love to hear your feedback after your visit. Please let us know where we can improve.
Also feel free to share your positive feedback on social media or with a Google Review. We get so much joy from having an opportunity to help another child (family).

Thank you so much for choosing Link Dental Health!

Patient Form

healthystart®

Doctor / Dentist: _____

Patient's Name: _____ DOB: _____ Age: _____

Relationship to Patient: _____ Pediatrician: _____

Sleep Disordered Breathing Questionnaire for Children

Earl O. Bergersen, DDS, MSD

Please indicate to what degree your child exhibits any of the following symptoms using the scale of severity below. The initial score column should be evaluated and dates at first appointment and the follow-up score column should be evaluated and dated after 3 months of treatment by the same person who filled out the initial assessment.

Date of Initial Assessment: _____ Date of Follow-up Assessment: _____

Filled Out By: _____ Filled Out By: _____

Not Present: 0 | Very Mild: 1 | Mild: 2 | Moderate: 3 | Pronounced: 4 | Severe: 5

	INITAL SCORE	FOLLOW-UP SCORE	
1.	____	____	Snoring of any kind
2.	____	____	Snores only infrequently (1 night/week)
3.	____	____	Snores fairly often (2-4 nights/week)
4.	____	____	Snores habitually (5-7 nights/week)
5.	____	____	Has labored, difficult, loud breathing at night
6.	____	____	Has interrupted snoring where breathing stops for 4 or more seconds
7.	____	____	Had stoppage of breathing more than 2 times in an hour
8.	____	____	Hyperactive
9.	____	____	Mouth breathes during day
10.	____	____	Mouth breathes while sleeping
11.	____	____	Frequent headaches in morning
12.	____	____	Allergic symptoms ☐ Food allergies ☐ Asthma ☐ Eczema ☐ Nasal Congestion ☐ Seasonal ☐ Animal ☐ Other:
13.	____	____	Excessive sweating while asleep
14.	____	____	Talks or walks in sleep
15.	____	____	Poor ability in school* ☐ Math ☐ Science ☐ Spelling ☐ Reading ☐ Writing ☐ Behavior Problems
16.	____	____	Falls asleep watching TV or at school
17.	____	____	Wakes up at night
18.	____	____	Attention deficit
19.	____	____	Restless Sleep
20.	____	____	Grinds Teeth
21.	____	____	Frequent throat or other infections
22.	____	____	Frequent ear infections
23.	____	____	Feels sleepy and/or irritable during the day
24.	____	____	Has a difficult time listening and often interupts
25.	____	____	Fidgets with hands or does not sit quietly* ☐ Nervous muscular tics ☐ Restless (wiggles) legs
26.	____	____	Ever wets the bed
27.	____	____	Exhibits bluish color at night or during the day or under eyes
28.	____	____	Nightmares and/or night terrors
29.	____	____	Exhibits any of the following*: ☐ Rarely smiles ☐ Feels sad ☐ Feels depressed
30.	____	____	Speech problems**
31.	____	____	Nasal breathing difficult ☐ Normal nasal breathing ☐ Can't breathe through nose
32.	____	____	Resists routines and directions

*Please indicate with a X if condition is present

** If scored greater than 0, please continue to Speech Questionnaire on page 2 (reverse side)Please indicate with a X if condition is present

Revised 12/2020

Based on Sahin et al, 2009; and Urschitz et al, 2004; AM Thoracic Soc Stand, 1996; Attanasio et al, 2010

Patient Form

Continued from question #30 on reverse side

healthystart®

Speech Questionnaire for Children

Earl O. Bergersen, DDS, MSD

Not Present: 0 | Very Mild: 1 | Mild: 2 | Moderate: 3 | Pronounced: 4 | Severe: 5

Speech Assessment

	INITIAL SCORE	FOLLOW-UP SCORE	
33.	_____	_____	Do you or do others have difficulty understand your child's speech?
34.	_____	_____	Difficult to understand over the phone
35.	_____	_____	Uses grunts or screams more than words
36.	_____	_____	Lisp
37.	_____	_____	Hoarseness
38.	_____	_____	Nasal speech
39.	_____	_____	Becomes frustrated when attempting to speak
40.	_____	_____	Often uses words with only 1 or 2 syllables

	INITIAL SCORE	FOLLOW-UP SCORE	
41.	_____	_____	Seems winded when increasing volume
42.	_____	_____	Any difficulty in swallowing
43.	_____	_____	Stutters
			Any family history of a stutter? ☐Yes ☐No
44.	_____	_____	Tourette's Syndrome
45.	_____	_____	Family history of a speech or language disorder
46.	_____	_____	Any speech therapy? If so, how long? _____

Specific Articulation Questions

	INITIAL SCORE	FOLLOW-UP SCORE	
47.	_____	_____	Child replaces a "t, d, n, s, z, th or l" with a "p, b, m, w, f, or v" Example: "hap" for "hat", "kif" for "kiss", "fum" for "thumb", or "bav" for "bath"
48.	_____	_____	Child replaces an "r" with a "w" or an "L" with a "w" or a "y" Example: "wabbit" for "rabbit", "yewo" for yellow "weg" for "leg", "pway" for "play", "wun, for "run"
49.	_____	_____	Child replaces a "s, f, v, z, th, j, or h" with a consonant such as "p, b, t, d, k, g" Example: "tock" for "sock", "dump" for "jump", "pan" for fan", "bat" for "fat"
50.	_____	_____	Child replaces a "p, b, m, w, th, f, or v" with a "t, d, s, z, n, or l" Example: "sum" for "thumb", "muhzer" for "mother"
51.	_____	_____	Child replaces a "t" or a "d" with "k" or "g" Example: "gog" for "dog", "cop" for "top", "boke" for "boat", "key" for "tea"

	INITIAL SCORE	FOLLOW-UP SCORE	
52.	_____	_____	Child replaces a "ch" or a "j" sound with a "sh, v, f, th, or s" Example: "ship" for "chip", "shoo shoo" for "choo choo"
53.	_____	_____	Child changes position of a sound within a word Example: "pasghetti" for "spaghetti", "efelant" for "elephant", "baksit" for "basket"
54.	_____	_____	Child inserts "uh" into words Example: "stuh-reet" for "street", "fuh-wog" for "frog", "buh-lue" for "blue", "puh-lease" for "please"
55.	_____	_____	Child replaces a "k" or a "g" with "t" or "d" Example: "doat" for "goat", "tuhtie" for "cookie", "tup" for "cup", "hud" for "hug"
56.	_____	_____	Child replaces a "sh" with an "s" Example: "sue" for "shoe", "sip" for "ship", "mezza" for "measure"

Based on Bauman-Waegler, J.A. 2012, Bernthal, et al. 2013, Bowen 1998, and Grunwell 1997

Revised 12/2019

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HIPAA ACKNOWLEDGEMENT

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

A copy of the Notice of Privacy Practices is available for you upon request.

RELEASE OF INFORMATION

Please let us know how your personal health information may be released:

☐ I am the only one who should receive information regarding my personal health information.

Best way to contact me:

Home phone _____ Permission to leave a message? ☐ Yes ☐ No

Cell Phone _____ Permission to leave a message? ☐ Yes ☐ No

☐ I, _____, authorize the release of my medical information including appointment information, diagnosis, records, examination rendered to me and claims/billing information. This information may be released to:

Name	**Relationship**	**Phone #**

Patient Name (please print): _____

Patient Signature: _____

Date: _____

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HIPAA POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this might include coordinating medication with your medical doctor, implant services, lab services etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this might be filing a claim with your insurance company.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to aggress to a requested restriction. If we do agree to a restriction, we must abide by it unless you aggress in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office, or with the Department of Health & Human Services at the address below, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.