DR. YULIA PATERSON
DDS, NMD, IBDM

PATIENT INFORMATION

Welcome!
On behalf of Dr. Yulia and the entire staff here at Link Dental Health, welcome to our practice! We appreciate the trust you have placed in us, and we will strive to use the latest research and science to provide the highest quality of dental care that you expect. Our goal is to focus on the whole patient allowing us to utilize the root cause approach, rather than just treating dental symptoms. Please fill out the intake forms to allow us to learn more about you. Everything you share is confidential and will be used for diagnostic and educational purposes. We very much look forward to serving all of your family's needs for many years to come.

Name: _____
Last Name First Name MI Preferred Name

Address: _____
Address City State Zip Code

Phone #: _____ Cell #: _____ Email: _____

DOB: _____ SS#: _____ Gender: ☐ M ☐ F Married ☐ Single ☐

Emergency Contact: _____
Name Phone # Relationship

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 provided through an Employer ☐ Self Purchased Policy

Insurance Policy 1

Your relationship to the subscriber: ☐ Self ☐ Spouse ☐ Dependent

Subscriber Name: _____ Subscriber DOB: _____

Insurance Company: _____ Employer/Group Name: _____

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

Insurance Policy 2

Your relationship to the subscriber: ☐ Self ☐ Spouse ☐ Dependent

Subscriber Name: _____ Subscriber DOB: _____

Insurance Company: _____ Employer/Group Name: _____

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

DR. YULIA PATERSON

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DENTAL HISTORY

Name: _____ Age: _____
Last Name First Name MI Preferred Name

Previous Dentist: _____ Date of most recent dental exam/cleaning: ___/___/___

Date of most recent x-rays: ___/___/___ Date of most recent dental treatment (other than cleaning): ___/___/___

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

I routinely see my dentist every ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY:	**YES**	**NO**
1. Are you fearful of treatment? How fearful, on a scale of 1 (least) to 10 (most)_____	☐	☐
2. Have you had an unfavorable dental experience?_____	☐	☐
3. Have you ever had complications from past dental treatment?_____	☐	☐
4. Have you ever had trouble getting numb or any reactions to local anesthetic?_____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?_____	☐	☐
6. Have you ever had teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?_____	☐	☐
GUM AND BONE:	**YES**	**NO**
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?_____	☐	☐
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have bone loss around your teeth?_____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?_____	☐	☐
10. Is there anyone with a history of periodontal disease in your family?_____	☐	☐
11. Have you ever experienced gum recession, or can you see the roots of your teeth?_____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?_____	☐	☐
13. Have you ever experienced a burning or painful sensation in your mouth not related to your teeth?_____	☐	☐
TOOTH STRUCTURE:	**YES**	**NO**
14. Have you had any cavities in the past 3 years?_____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have any difficulty swallowing any food?_____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?_____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?_____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?_____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?_____	☐	☐
20. Do you frequently get food caught between any teeth?_____	☐	☐
BITE AND JAW JOINT:	**YES**	**NO**
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)_____	☐	☐
22. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?_____	☐	☐
23. In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?_____	☐	☐
24. Are your teeth becoming more crooked, crowded, or overlapped?_____	☐	☐
25. Are your teeth developing spaces or becoming more loose?_____	☐	☐
26. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?_____	☐	☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?_____	☐	☐
28. Do you clench or grind your teeth together in the daytime or make them sore?_____	☐	☐
29. Do you wear or have you ever worn a bite appliance?_____	☐	☐
SMILE CHARACTERISTICS:	**YES**	**NO**
30. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?_	☐	☐
31. Have you ever bleached (whitened) your teeth?_____	☐	☐
32. Have you felt uncomfortable or self conscious about the appearance of your teeth?_____	☐	☐
33. Have you ever been disappointed with the appearance of previous dental work?_____	☐	☐

Patient's Signature _____ Date _____

LINK DENTAL HEALTH

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MEDICAL HISTORY

Name: _____ Age: _____
Last Name First Name MI Preferred Name

Name of Physician and their specialty: _____

Most recent physical examination: _____ Purpose: _____

Most recent bloodwork (CBC): _____ Vitamin D Level: _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU or HAVE YOU EVER HAD:

	YES	NO
1. Hospitalization for illness or injury_____ If so, please list _____	☐	☐
2. Allergies or bad reactions to anything? If so, please list _____	☐	☐
3. Heart problems, or cardiac stent within the last 6 months_	☐	☐
4. History of infective endocarditis _____	☐	☐
5. Artificial heart valve, repaired heart defect (PFO)_____	☐	☐
6. Pacemaker or implantable defibrillator _____	☐	☐
7. Orthopedic, soft tissue implant (ex: joint replacement, breast implant)_____	☐	☐
8. Heart murmur, rheumatic or scarlet fever_____	☐	☐
9. High or low blood pressure _____	☐	☐
10. A stroke (taking blood thinners)_____	☐	☐
11. Anemia or other blood disorder _____	☐	☐
12. Prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. Pneumonia, emphysema, shortness of breath, sarcoidosis	☐	☐
14. Chronic ear infections, tuberculosis, measles, chicken pox	☐	☐
15. Breathing problems (ex: asthma, stuffy nose, sinus congestion) _____	☐	☐
16. Sleep problems (ex: sleep apnea, snoring, insomnia, restless sleep, bed wetting) _____	☐	☐
17. Kidney disease _____	☐	☐
18. Liver disease or jaundice _____	☐	☐
19. Vertigo (ex: “the room is spinning”) _____	☐	☐
20. Thyroid, parathyroid disease, or calcium deficiency_____	☐	☐
21. Hormone deficiency or imbalance (ex: polycystic ovarian syndrome)_____	☐	☐
22. High cholesterol or taking statin drugs _____	☐	☐
23. Diabetes (hbA1c= _____)	☐	☐
24. Stomach or duodenal ulcer _____	☐	☐
25. Digestive or eating disorders (ex: celiac disease, gastric reflux, bulimia, anorexia_____	☐	☐
26. Osteoporosis/osteopenia or ever taken anti-resorptive medications (ex: bisphosphonates) _____	☐	☐

	YES	NO
27. Arthritis or gout _____	☐	☐
28. Autoimmune disease (ex: rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. Glaucoma_____	☐	☐
30. Contact Lenses_____	☐	☐
31. Head or neck injuries_____	☐	☐
32. Epilepsy, convulsions (seizures)_____	☐	☐
33. Neurological disorders (ex:Alzheimer’s disease, dementia, prion disease)_____	☐	☐
34. Viral infections and cold sores_____	☐	☐
35. Any lumps or swelling in the mouth_____	☐	☐
36. Hives, skin rash, hay fever_____	☐	☐
37. STI / STD / HPV_____	☐	☐
38. Hepatitis (Type_____) _____	☐	☐
39. HIV / AIDS_____	☐	☐
40. Tumor, abnormal growth_____	☐	☐
41. Radiation therapy_____	☐	☐
42. Chemotherapy, immunosuppressive medication_____	☐	☐
43. Emotional difficulties_____	☐	☐
44. Psychiatric treatment or antidepressant medication_____	☐	☐
45. Concentration problems or ADD / ADHD_____	☐	☐
46. Alcohol / recreational drug use_____	☐	☐

ARE YOU:

47. Presently being treated for any other illnesses_____	☐	☐
48. Aware of change in your health in the last 24 hours (ex: fever, chills, new cough, or diarrhea)_____	☐	☐
49. Taking medications for weight management_____	☐	☐
50. Taking dietary supplements, vitamins and/or probiotics____	☐	☐
51. Often exhausted or fatigued_____	☐	☐
52. Experiencing frequent headaches or chronic pain_____	☐	☐
53. A smoker, smoked previously or other (ex: smokeless tobacco, vaping, e-cigarettes, and cannabis)_____	☐	☐
54. Considered a touchy/sensitive person_____	☐	☐
55. Often unhappy or depressed_____	☐	☐
56. Taking birth control pills_____	☐	☐
57. Currently pregnant_____	☐	☐
58. Diagnosed with a prostate disorder_____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (ex: Botox, Collagen injections)_____

_____

_____

List all medications, supplements, vitamins and/or probiotics taken within the last 2 years:

Drug	Purpose	Drug	Purpose

Patient Signature_____ Date_____

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SLEEP AND BREATHING QUESTIONNAIRE

Have you ever had a sleep test administered? ☐Yes ☐No

If yes - when did you have your last sleep test? _____

Have you ever been diagnosed with Sleep Apnea? ☐Yes ☐No

Do you currently use a CPAP or Sleep Apnea Appliance? ☐Yes ☐No

If yes - are you happy with your CPAP or Sleep Appliance? ☐Yes ☐No

If you are not happy - why? _____

How often do you get out of bed to use the restroom during the night? _____

Do you usually wake feeling tired or unrested? ☐Yes ☐No

Do you habitually snore? ☐Yes ☐No

Have you been diagnosed with Hypertension/High Blood Pressure? ☐Yes ☐No

Do you suffer from waking headaches? ☐Yes ☐No

Do you regularly experience daytime drowsiness or fatigue? ☐Yes ☐No

Do you have blocked nasal passages? ☐Yes ☐No

Has anyone ever observed you stop breathing during your sleep? ☐Yes ☐No

Do you ever wake up choking or gasping? ☐Yes ☐No

Do you grind your teeth while sleeping? ☐Yes ☐No

Please list any additional medical conditions:

_____

_____

_____

_____

I understand the above information and attest that this information is accurate and complete to the best of my knowledge.

Patient Name: _____ Patient Date of Birth: _____
(Please Print)

Patient Signature: _____ Today's Date: _____

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PATIENT SPECIAL REQUEST FORM

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Part of our mission here at Link Dental Health is to deliver exceptional customer service and patient care. In doing so, we want to know what we can do to enhance the quality and comfort of your experience. Please let us know if you have any special request for your visit by indicating below.

☐ **I do not have any special requests.**

☐ **I would like to make the following requests:**

- ☐ Please provide me with an airway consultation.
- ☐ Please speak with me about removing my amalgam (mercury/silver) fillings.
- ☐ Please utilize gluten free products.
- ☐ I would like to schedule a nutritional assessment.

Other Requests:

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

Name if Not the Patient: _____ Relationship to Patient: _____

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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.

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