William T. Link, DDS, PA
Patient Information

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

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

DOB:_____ ❒ Male ❒ Female SS#:_____

Address:_____ City:_____ State:_____ Zip:_____

Employer:_____

State ID/Driver's License #:_____ E-mail Address:_____

Name of Physician:_____ Physician Phone:_____

In case of Emergency Contact:_____ Relationship:_____ Phone:_____

How did you hear about our office?_____

Patient Health History

	Yes	No
Abnormal bleeding	❒	❒
AIDS/HIV	❒	❒
Anemia	❒	❒
Arthritis/Osteoarthritis/Rheumatoid	❒	❒
Asthma/Difficulty breathing/ Shortness of breath	❒	❒
Autoimmune disease	❒	❒
Cancer/Radiation/Chemotherapy	❒	❒
Cardiovascular disease		
Angina	❒	❒
Arteriosclerosis	❒	❒
Congestive HF	❒	❒
Coronary artery disease	❒	❒
Heart attack	❒	❒
Heart murmur	❒	❒
Stroke	❒	❒
High blood pressure	❒	❒
Low blood pressure	❒	❒
Mitral valve prolapse	❒	❒
Pacemaker	❒	❒
AFIB	❒	❒
Diabetes	❒	❒
Depression/anxiety/nervousness	❒	❒
Dry eyes	❒	❒
Dry mouth	❒	❒
Eating disorder	❒	❒
Epilepsy	❒	❒
Fainting spells or seizures	❒	❒
Gastrointestinal disease	❒	❒
GERD/ reflux	❒	❒
Glaucoma	❒	❒
Herpes/fever blisters	❒	❒
Hemophilia	❒	❒
Hepatitis A,B, or C	❒	❒
Kidney disease / dialysis	❒	❒
Leukemia	❒	❒
Lung disease	❒	❒
Lupus / SLE	❒	❒
Respiratory problems / Emphysema/ Bronchitis	❒	❒
Mental health disorder / Psychiatric care	❒	❒
Osteoporosis	❒	❒
Severe headaches/ Migraines	❒	❒
Sinus problems / sinusitis	❒	❒
Shingles	❒	❒
Sleeping disorder	❒	❒
Stomach problems /Ulcers	❒	❒
Tuberculosis	❒	❒
Thyroid problems	❒	❒
Tumor	❒	❒

Medical Questions

WOMEN ONLY: Are you ❒ Pregnant/trying to get pregnant? ❒ Taking oral contraceptives? ❒ Hormonal replacement? ❒ Nursing?

Allergies- Are you allergic to or have you had a reaction to: Mark an X to all that apply, specify type of reaction.

❒ Local anesthetics
❒ Aspirin/NSAIDS (ibuprofen)
❒ Amoxicillin/Penicillin
❒ Barbiturates, sedatives, or sleeping pills
❒ Codeine or other narcotics
❒ Iodine
❒ Metals
❒ Latex (rubber)
❒ Hay fever/seasonal
❒ Sulfa drugs
❒ Animals
❒ Food_____
❒ Other: _____
_____
_____

Please ☒ a response to indicate if you have had any of the following diseases or problems.

❒ Artificial (prosthetic) heart valve
❒ Previous infective endocarditis
❒ Damaged valves in transplanted heart
❒ Congenital heart disease (CHD)/Defect
❒ Unrepaired, cyanotic CHD
❒ Repaired (completely) in the past 6 months
❒ Repaired CHD with residual defects

❒ JOINT REPLACEMENT. have you had an orthopedic total joint (hi, knee, elbow, finger) replacement? Yes ❒ No ❒

Date:_____ If yes, have you had any complications?
_____
_____
_____

Medical Information: Please mark ☒ your response to indicate if you have or had any of the following.

❒ Do you wear contact lenses?
❒ Are you currently taking a blood thinner? If yes, please explain:_____
❒ Are you taking, have you taken or are you scheduled to take any oral or IV Bisphosphonates? If yes, please explain:_____
❒ Have you had any problems or complications with any surgeries or anesthesia? If yes, please explain:_____
❒ Do you use controlled substances (drugs)? If yes, please explain:_____
❒ Do you use/used tobacco (smoking, snuff, chew)? If yes, how much? _____ # of years? _____ Year quit?_____
❒ Alcohol: Daily/Weekly/Rarely/Never If yes, how much aldocol did you drink in the last 24 hours? _____

Do you have any disease, condition, or problem not listed above that we should know about? Please explain:_____
_____

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? Yes ❒ No ❒
Name of physician or dentist making recommendation:_____ Phone:_____

List any medications you are taking including nonprescription drugs:

_____ _____
_____ _____
_____ _____

Date of last medical exam: _____

SLEEP SCREENING QUESTIONNAIRES

Please answer the questions below to help us assess for possible sleep apnea, a condition in which your breathing pauses or stops for periods of time while you sleep. Sleep apnea can increase your risk for many health conditions. It can also increase your risk for breathing problems after surgery.

Height_____ Weight _____

	Yes	No
Have you ever been diagnosed with obstructive sleep apnea (OSA)?	❒	❒
Are you currently being treated for OSA?	❒	❒
Are you aware of a family history of OSA?	❒	❒
Are you aware of clenching or grinding your teeth at night?	❒	❒

STOP-BANG

	Yes	No
1. Snore Do you snore loudly? (Louder than talking or loud enough to be heard behind a closed door?)	❒	❒
2. Tired Do you often feel tired, fatigued or sleepy during the daytime?	❒	❒
3. Obstruction Has anyone observed you stop breathing during your sleep?	❒	❒
4. Pressure Do you have or are you being treated for high blood pressure?	❒	❒
5. BMI Is your body mass index greater than 28?	❒	❒
6. Age Are you 50 years old or older?	❒	❒
7. Neck Are you a male with neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches?	❒	❒
8. Gender Are you a male?	❒	❒

Total Yes Answers _____

If you have 3 or more YES answers to STOP-BANG, a sleep study is recommended.

Dental History Information

Date of last dental visit?_____

Name of your previous dentist_____

Reason for today's visit?_____

Have you ever had an oral cancer screening? ..... ❒ YES ❒ No

How often do you floss your teeth?_____

Do your gums bleed when you brush? ..... ❒ YES ❒ No

Have you or a family member ever been treated for peridontal disease? ..... ❒ YES ❒ No

Have you ever had complications from an extraction? ..... ❒ YES ❒ No

Have you ever had a popping or clicking near your ear when you chew? ..... ❒ YES ❒ No

Are you prone to frequent headaches? ..... ❒ YES ❒ No

Do you have sores, blisters or swelling on your gums, lips or cheeks? ..... ❒ YES ❒ No

Have you ever had orthodontic treatment? ..... ❒ YES ❒ No

Do you have problems with bad breath? ..... ❒ YES ❒ No

Have you ever had an allergic reactions to a crown, metal filling or dental appliance? ..... ❒ YES ❒ No

Have you ever used an electric toothbrush? ..... ❒ YES ❒ No

Are your teeth sensitive to hot, cold or pressure? ..... ❒ YES ❒ No

On a scale from 1 to 10 with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

If you could change something about your smile what would it be:

- ❒ Whiter
- ❒ Straighter
- ❒ Close space
- ❒ Replace silver filling with tooth colored restorations
- ❒ Repair chipped teeth
- ❒ Replace missing teeth
- ❒ Less gum showing
- ❒ Replace old crowns or caps that don't match

My main concern about dental treatment is: ❒ time ❒ fear ❒ cost

We can help with all three!

I certify that I have read and understand the questions, above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Adult/Guardian: I hereby consent to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, or x-rays, as may be deemed necessary by the doctor.

Patient:_____ Date:_____

Parent/Guardian (*if patient is a minor*):_____ Date:_____