PAUL M. SANDVICK DDS
& ASSOCIATES
THE GENTLE ART OF CONSERVATIVE DENTISTRY

WELCOME

Patient's Name _____ Date of Birth ___/___/____ ☐ Male ☐ Female
Last First Initial

If child: Parent's Name _____

How do you wish to be addressed? _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Residence- Street_____

City _____ State _____ Zip _____

Telephone: Res _____ Bus. _____ Cell Phone: _____ Fax: _____

Email _____ (please write clearly)

Patient/Parent Employed By: _____ Present Position: _____

Who is responsible for this account?_____

Method of Payment: ☐ Insurance ☐ Cash ☐ Credit Card

Other family members in this practice? _____

How did you hear about us?

☐ google/internet search ☐ Facebook/social media ☐ Print Media ☐ Physician or Specialist: _____

☐ referral from existing patient ☐ referral from another community member ☐ Other _____

If referred to us, whom shall we thank? _____

Emergency Contact Name: _____ Relation to you _____ Emergency Phone: _____

Consent:
I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to the following person who are involved in my care (or my child's care) or payment for that care:

_____

_____

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid by my dental care payor.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature:_____ Date: _____

PAUL M. SANDVICK DDS
& ASSOCIATES
THE GENTLE ART OF CONSERVATIVE DENTISTRY

MEDICAL HISTORY

PATIENT'S NAME _____ Date of Birth _____ Phone: _____

Primary Care Physician's Name _____ Primary Care Physician Ph: _____

Name your preferred Pharmacy: _____ Ph number: _____

1. Are you under a physician's care (non-routine) at this time ____ Yes _____ No

If yes, for what condition: _____

2. Have you been hospitalized in the last year? ____ Yes _____ No

If yes, list reason: _____

3. What medications do you currently take (prescription, non-prescription, IV, or aspirin?)

Medication/For Treatment of: Medication/For Treatment of:

_____ _____

_____ _____

_____ _____

_____ _____

4. Health Conditions:

Health Condition	Yes	No
Allergy-Medications		
Allergy- Other		
Anemia		
Anorexia/Bulemia		
Anxiety		
Arthritis		
Artificial Joints		
Asthma		
Blood Pressure: High		
Blood Pressure: Low		
Blood Thinners		
Cancer or Leukemia		
Chemotherapy		
Dementia		
Diabetes- Insulin		
Diabetes Oral		
Dizziness/Fainting		

Health Condition	Yes	No
Endocarditis- History of		
Epilepsy or Seizures		
Excessive Bleeding		
GERD or Acid Reflux		
Hearing Aid		
Heart Conditions		
Heart Valve Surgery		
Hepatitis		
HIV or AIDS		
Hypoglycemia		
Impaired Cognition		
Impaired Vision		
Organ Transplant: Date: _____		
Osteoporosis		
Osteoporosis- IV Med		
Pacemaker: Date: _____		

Health Condition	Yes	No
Pregnancy or Nursing- Current		
Psychiatric Care		
Radiation- History of		
Respiratory Problems		
Sinus Problems		
Stroke		
Thyroid Condition		
Tobacco Use		
Tuberculosis		
Any other conditions needing clarification:		

5. Are you allergic to or have you had any adverse reactions to drugs, foods, metals, and/or other substances? ____ Yes ____ No

If yes, please list allergy/reaction _____

6. Are you on birth control pills? ____ Yes ____ No

7. Has a physician ever recommended pre-medication before dental procedures? ____ Yes _____ No

If yes, please explain: _____

8. Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment?

_____

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

10. Previous Dentist Name and Phone number: _____

Date of most recent dental exam and dental x-rays (Approximate if not known): _____

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

11. What is your immediate concern? _____

12. Is there anything about the appearance of your smile that you would like to change?

_____

13. Please check any that apply:

Condition	✓
Complications from past dental treatment	
Had trouble getting numb	
Any reactions to anesthetic	
Had braces/orthodontic treatment	
Experience dry mouth	
Teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth:	
Food gets trapped between any teeth	
Concerns about crooked teeth or any cosmetic or functional issues:	
Experienced popping and/or clicking of your jaw joint (TMJ)	
Have you ever whitened or bleached your teeth?	

Condition	✓
Have difficulty chewing	
You clench or grind your teeth	
You wear or have worn a bite appliance	
Gums bleed when brushing or flossing	
Treated for gum disease or were told you have lost bone around your teeth:	
Teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth:	
Unpleasant taste or odor in your mouth	
Experienced gum recession	
Had any teeth become loose without injury	
Burning sensation in your mouth	

If any of the above need further explanation, please describe: _____

_____

14. By checking this box, I acknowledge that I have reviewed ALL questions on this questionnaire and responded accordingly. There are no other medical conditions or medication/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Patient Name: _____ Signature of Patient or Guardian: _____ Date: _____

Printed Name of person signing this form, if different from the patient:

_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ *(print name)* hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have reviewed the contents and agree to the following:

I allow you to give my clinical information to or answer questions from *(check all that apply)*:

- ☐ Spouse (name/phone #) _____
- ☐ Parent (name/phone #) _____
- ☐ Child (name/phone #) _____
- ☐ Other (name/phone #) _____
- ☐ None

I understand that by signing this form, I am confirming my written permission for the disclosure of my protected health information as described in the Notice of Privacy Practices and in this form:

Signature:_____ Date: _____

If this consent is signed by a personal representative/parent on behalf of the patient, complete the following:

Personal Representative's/Parent Name _____

Relationship to patient: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify) _____

PATIENT HEALTH HISTORY

Today's date: ___ /_____/_____

Patient Name:_____ **Cell Phone:** _____ **DOB:** ____/____/_____

Gender: ☐ **Male** ☐ **Female** **Weight lbs:** _____ **Height inches:** _____

Have you ever had a sleep study done? **Yes** **No** If yes, date: _____

Have you been diagnosed with sleep apnea before? **Yes** **No**

If yes, Sleep Physician Name and location: _____

Name of Current Dentist: _____How were you referred to us: _____

1. Personal Medical History:

- ☐ High Blood pressure
- ☐ Excessive Daytime Sleepiness
- ☐ Impaired cognition
- ☐ Mood disorders (depression, anxiety etc)
- ☐ Acid Reflux
- ☐ Heart Disease
- ☐ History of Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Worn front teeth
- ☐ Insomnia
- ☐ Nocturia (frequent urination at night)
- ☐ Sleep Medication

2. Family Medical History: (Please note any from list above that apply)_____

_____

3. Epworth Sleepiness Scale	No Chance of dozing	Slight Chance of dozing	Moderate chance of dozing	High Chance of dozing
1. Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
2. Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
3. Sitting inactive in a public place (like a Doctor's office, movie theater)	☐ 0	☐ 1	☐ 2	☐ 3
4. As a car passenger for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
5. Lying down to rest in the afternoon if given the chance	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking with someone	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
8. In a car, while stopped for a few minutes (in traffic or at a train)	☐ 0	☐ 1	☐ 2	☐ 3
Total		**(Add)**	**Total Score**	

4. Currently using a CPAP? **Yes** **No**

5. Have you been told that you snore loudly? **Yes** **No**

6. Has anyone observed you stop breathing or gasp during sleep? **Yes** **No**

☐