Welcome to Gaylord Family Dentistry

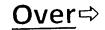
William P. Koenig, D.D.S. – David R. Rindfusz, D.D.S. – Jason L. Mantey, D.D.S.

Name			Preferred Name			
SS#		Date of birth				
Home address	Street		City	State	Zip	
Mailing address	P.O. Box		City	State	Zip	
Home phone num	ber			Cell number		
Employer				_ Work number		
Spouse name		· .		_ Phone number		
Responsible Party of minor				Relationship		
SS#		Date of Birth		Employer		
Emergency Contact Person.		<u> </u>		_ Phone number		
request. This also gives	RTHERN MICHIGAN NORTHERN MICH	N FAMILY DENTISTRY has po	sted their i	Release/Consent Form notice of Privacy Practices and a co	py is available to me upon ntal office upon my request.	
Signature:				· ·		
Date:						
approval of the American l	Dental Association. Changes in applical	This material is for general refe ble laws or regulations may requ	rence purpo Jire revision	ication or distribution by another party ses only and does not constitute legal . Dentists should contact qualified legal at of Health and Human Services rules a	advice. It covers only that A, the al counsel for legal advice,	
appropriate by the	e doctor to make	a thorough diagnosis of my	dental ne emplov su	dels, photographs, and other diag eds. Upon such diagnosis, I autho th treatment as required to provid understand that using anesthetic	le proper care. I agree to th	

I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment in full the day services are rendered on my behalf and my dependents. If I have insurance I also understand that payments such as co-pays, deductibles, and treatment not covered by my insurance must be paid in full at the time services are rendered.

I understand that my dental insurance carrier my pay less (we can only estimate) than the actual bill for services and the difference will be my responsibility to be paid within 30 days of receipt of statement.



Medical Health History

Family Physician		Office Phone	Date of Last Exam					
	Check If you have or have had any of the following:	Al	<u>lergies</u>					
	High Blood Pressure		Local Anesthetic (e.g. Novacaine)					
	Low Blood Pressure		Penicillin					
	Heart Disease		Codeine					
	Heart Attack	. 🗅	Latex Allergy					
			The state of the s					
	Chest Pain/Other Heart Trouble		Barbiturates (Sleeping Pills)					
	Cardiac Pacemaker		Sedatives					
	Stroke		Other					
	Easily Winded	_						
	Swollen Ankles		** -*					
	Alzheimer/Dementia		<u>edications</u>					
	Cancer		Are you taking any Medications?					
		If s	o, please list					
	• • • • • • • • • • • • • • • • • • • •							
	Kidney Disease							
0								
	Thyroid Problems							
	Emphysema		Herbal/Alternative Meds?					
	Asthma		Bisphosphonates/Osteoporosis Meds?					
	Hay Fever/Allergies							
	Respiratory Problems		· · · · · · · · · · · · · · · · · · ·					
			Do you use Tobacco?					
	Epilepsy/Convulsions		Do you use Drugs?					
	Diabetes		Do you use Alcohol?					
			Are you pregnant or think you may be pregnant?					
	Anemia Tub acculación		· , · · · · · · · · · · · · · · · · · · ·					
	Tuberculosis		, 3					
	Hepatitis/Jaundice		, , , , , , , , , , , , , , , , , , ,					
	,		the dentist for Artificial Joints or a Heart Condition?					
	Ulcers/Stomach Troubles		Have you had a Mitral Valve Prolapse?					
	Autoimmune Disease		Have you had Rheumatic Fever?					
	Recent Weight Loss	П	Have you had a Heart Murmur?					
	Glaucoma	ō	Have you had a Hip or Joint Replacement?					
	Arthritis	_	·					
<u> </u>	Other		Please check if "None" Applies to Medication					
		distant						
	Please check if "None" Applies to Medical Con	altions						
Dental Health History								
Previous	Dentist	·	Date of Last exam					
	Do you have any problems with your teeth such as, bleeding gu	ıms sensitive to h	attrold sweet/sour?					
	Do you feel any pain in any of your teeth, jaw or head?	inio, scholate to il	50 Cold, 51 CCQ 55011					
Have you experienced difficulty or prolonged bleeding after teeth extractions?								
	Have you had instruction on the correct way to care for your te	eth and gums?						
L certify th	nat I have read and understand the above information to the best o	f my knowledae. T	he above questions have been accurately answered. I					
	nd that providing incorrect information can be dangerous to my hea		and a decoration in the a decoration, and included in					
		•						
Signature	of Patient/Responsible Party		Date					
Doctor's	Comments							