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 number _____ Cell number _____

Employer _____ Work number _____

Spouse name _____ Phone number _____

Responsible Party of minor _____ Relationship _____

SS# _____ Date of Birth _____ Employer _____

Emergency Contact Person._____ Phone number _____

Patient Acknowledgment and X-Ray Release/Consent Form

I acknowledge that NORTHERN MICHIGAN FAMILY DENTISTRY has posted their notice of Privacy Practices and a copy is available to me upon request. This also gives NORTHERN MICHIGAN FAMILY DENTISTRY permission to release my X-Rays to another dental office upon my request.

Print Name:_____

Signature:_____

Date:_____

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such treatment as required to provide proper care. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents embody certain risk. 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.

Over⇨

Medical Health History

Family Physician_____Office Phone _____ Date of Last Exam_____

Please Check If you have or have had any of the following:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Stent Placed
- ☐ Chest Pain/Other Heart Trouble
- ☐ Cardiac Pacemaker
- ☐ Stroke
- ☐ Easily Winded
- ☐ Swollen Ankles
- ☐ Alzheimer/Dementia
- ☐ Cancer
- ☐ Leukemia
- ☐ Radiation Therapy
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Problems
- ☐ Emphysema
- ☐ Asthma
- ☐ Hay Fever/Allergies
- ☐ Respiratory Problems
- ☐ Fainting/Seizures
- ☐ Epilepsy/Convulsions
- ☐ Diabetes
- ☐ AIDS or HIV infection
- ☐ Anemia
- ☐ Tuberculosis
- ☐ Hepatitis/Jaundice
- ☐ Sexually Transmitted Disease
- ☐ Ulcers/Stomach Troubles
- ☐ Autoimmune Disease
- ☐ Recent Weight Loss
- ☐ Glaucoma
- ☐ Arthritis
- ☐ Other _____
- ☐ *Please check if "None" Applies to Medical Conditions*

Allergies

- ☐ Local Anesthetic (e.g. Novacaine)
- ☐ Penicillin
- ☐ Codeine
- ☐ Latex Allergy
- ☐ Sulfa Drugs
- ☐ Barbiturates (Sleeping Pills)
- ☐ Sedatives
- ☐ Other _____

Medications

- ☐ Are you taking any Medications?

If so, please list

_____

_____

_____

- ☐ Herbal/Alternative Meds?
- ☐ Bisphosphonates/Osteoporosis Meds?
- ☐ Non-prescription Meds?
- ☐ Have you been hospitalized for any surgical or serious injury?
- ☐ Do you use Tobacco?
- ☐ Do you use Drugs?
- ☐ Do you use Alcohol?
- ☐ Are you pregnant or think you may be pregnant?
- ☐ Are you nursing?
- ☐ Are you taking Birth control Pills?
- ☐ Are you currently or have you ever been Pre-Medicated to go to the dentist for Artificial Joints or a Heart Condition?
- ☐ Have you had a Mitral Valve Prolapse?
- ☐ Have you had Rheumatic Fever?
- ☐ Have you had a Heart Murmur?
- ☐ Have you had a Hip or Joint Replacement?
- ☐ *Please check if "None" Applies to Medications*

Dental Health History

Previous Dentist_____ Date of Last exam_____

- ☐ Do you have any problems with your teeth such as, bleeding gums, sensitive to hot/cold, sweet/sour?
- ☐ Do you feel any pain in any of your teeth, jaw or head?
- ☐ Have you experienced problems with clicking, difficulty opening or closing, chewing, grinding or clenching your teeth?
- ☐ Have you experienced difficulty or prolonged bleeding after teeth extractions?
- ☐ Have you had instruction on the correct way to care for your teeth and gums?

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient/Responsible Party_____Date_____

Doctor's Comments_____