

**MGDC Patient Scheduling Form- (must be returned to office prior to scheduling)**

E-mail: mgdc@drmarymfisher.com

Phone: 248-932-9243 (Voicemail line)

Name of Community: \_\_\_\_\_ Room # \_\_\_\_\_

Patient Name: \_\_\_\_\_ (include middle initial). Patient's DOB: \_\_\_\_\_

Responsible Party: (Financial Power of Attorney – POA, Guardian, Conservator:

Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

Billing Address of Financial POA to send statement: \_\_\_\_\_

Billing Email of financial POA to send statement: \_\_\_\_\_

The best phone number for Dr. Fisher to reach POA during the appointment:

(H) (W) (C) \_\_\_\_\_.

Alternate Number if we cannot reach you at first number: (H) (W) (C) \_\_\_\_\_

Allergies: \_\_\_\_\_

(Ex: Latex, Penicillin, Mycins, Sulfa, Anesthetic, etc.....)

Joint replacements? (Knee, Hip, Shoulder) or (pins, plates, rods)? \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Any of the following: Heart Murmur, Pacemaker, Atrial Fibrillation (A-Fib), Mitral Valve Prolapse (MVP) \_\_\_\_\_

Heart Valve Replacement, or Congestive Heart Failure (CHF)? \_\_\_\_\_ Date: \_\_\_\_\_

Any Strokes or Seizures? \_\_\_\_\_ Date: \_\_\_\_\_

Any Stents, Ports, or Heart Bypass Surgery? \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

On Blood Thinners? \_\_\_\_\_ (Ex: Coumadin, Plavix, Warfarin, Eliquis, Pradaxa, Xarelto, etc.....)

Take daily Aspirin? if so, is it 81mg. or 325 mg.? \_\_\_\_\_

Diabetic? Insulin or Non-Insulin Dependent? \_\_\_\_\_

Does Patient have his/her own teeth or partials or dentures? \_\_\_\_\_

Does Patient have dental insurance? \_\_\_\_\_ If so, name of Carrier \_\_\_\_\_ Group# \_\_\_\_\_

Member ID# \_\_\_\_\_ Do you have a card? \_\_\_\_\_ Can you send a picture? \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_