GREATER MICHIGAN
ORAL SURGEONS &
DENTAL IMPLANT CENTER, P.C.

Michael S. Frey, DDS
Robert C. Lesneski, DDS
Christopher P. Kittle, DDS

General Patient Information

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____ Sex: ☐ M ☐ F

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Birthdate: _____ Soc. Sec. #: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Email Address: _____ Emergency Contact: _____

Contact Phone: _____ Relation to Emergency Contact: _____

Referred By: _____

Dentist: _____

Physician: _____

PERSON RESPONSIBLE FOR ACCOUNT:

First: _____ MI: _____ Last: _____ S.S. #: _____

Address (if different than patient): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Birthdate: _____ Employer: _____ Relation to Patient: _____

INSURANCE INFORMATION:

Dental Insurance

Primary Dental Insurance: _____ Employer: _____

Cardholder Name: _____ S.S. #: _____ Cardholder DOB: _____

Secondary Dental Insurance: _____ Employer: _____

Cardholder Name: _____ S.S. #: _____ Cardholder DOB: _____

Medical Insurance

Primary Medical Insurance: _____ Employer: _____

Secondary Medical Insurance: _____ Employer: _____

The signature below gives authorization and permission to be used as a copy in place of the original signature on all insurance submissions. The signature also authorizes payment to be made directly to Dr. Frey, Dr. Lesneski, and Dr. Kittle. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered by the above doctors.

Signature: _____ Date: _____

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Patient Medical History

Name: _____ Date: _____

ALLERGIES: Please list any known allergies.

_____

_____

MEDICATIONS: Please list all current medications.

_____

_____

- Date of last complete physical by a physician: _____
  List surgical history: _____
  _____
- Have you ever had anesthesia or sedation? ☐ Yes ☐ No
- Have you ever had any reactions to anesthesia? ☐ Yes ☐ No
- Have you ever had orthodontic treatment (braces)? ☐ Yes ☐ No
- Do you have or have you ever had temporomandibular joint problems (TMJ)? ☐ Yes ☐ No
  ☐ **Clicking** ☐ **Jaw Locking** ☐ **Right** ☐ **Left**
- Have you ever had facial bone or jaw fractures? ☐ Yes ☐ No
- Have you ever had jaw surgery? ☐ Yes ☐ No

Please check any of the following which you have had or have at present:

☐ Angina Pectoris (chest pain)
Date of Last Episode:
_____
☐ Heart Attack
☐ Heart Surgery
Type: _____
Date: _____
☐ Heart Disease
☐ Stroke
Date: _____
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Rheumatic Fever
☐ Congenital Heart Defects
☐ Irregular Heart Beat
☐ Mitral Valve Prolapse/Heart Murmur
☐ Congestive Heart Failure
☐ Breathing Problem
☐ Shortness of Breath
☐ Lung Disease (COPD, Emphysema)
☐ Asthma
☐ Sinus Trouble
☐ Sleep Apnea
☐ **CPAP Use**
☐ Diabetes
☐ **Insulin Use**

☐ Kidney Disease
☐ **Dialysis**
☐ Ulcers
☐ Liver Disease
☐ Bleeding or Clotting Disorder, Blood Clots
☐ Thyroid Disease
☐ Psychiatric Treatment
For: _____
☐ Dementia
☐ Alzheimer's
☐ Seizures or Epilepsy
Date of Last Seizure:
_____
☐ Mental Impairment
☐ **ADHD/ADD**
☐ **Autism**
☐ **Other:** _____
☐ Hearing Impairment
☐ Glaucoma
☐ Cancer
Type: _____
Location: _____
☐ Radiation
Date: _____
Area of Body: _____

☐ Chemotherapy
Date: _____
☐ Joint Replacement Surgery
Date: _____
Location: _____
☐ Hepatitis:
☐ **Type A** ☐ **Type B** ☐ **Type C**
☐ Recreational Drug Use
Type: _____
☐ Alcohol or Drug Addiction Treatment
Date: _____
☐ HIV/AIDS
☐ Tobacco Use
Type: _____
How Often? _____
☐ Alcohol Use
How Often? _____
☐ Sexually Transmitted Disease
☐ Blood Transfusion
When? _____
☐ Steroid Use
☐ Bisphosphonate Use
How Long? _____
(e.g., Fosamax®, Didronel®, Boniva®, Aredia®, Actonel®, Skelid®, Reclast®, Zometa®)

WOMEN ONLY:

- Is there any chance you could be pregnant now? ☐ Yes ☐ No
  If yes, how long? _____
- Are you currently breastfeeding? ☐ Yes ☐ No
- Are you on birth control pills? ☐ Yes ☐ No

Signature: _____ Date: _____

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PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Patient Acknowledgement

_____ I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ I acknowledge that I did not want a copy of this office's Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (please print)

_____

Date

For Office Use Only

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

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other_____

_____ _____

Office Personnel Signature Office Personnel (please print)

_____

Date

Patient Consent

Existing Michigan Law also requires us to first obtain your written consent prior to disclosing any of your information, except for our disclosures in connection with a defense to a claim challenging our professional competence, a review entity's functions, a claim for payment of fees, a third-party payer's examination of our records, a court order as part of a criminal investigation, an identification of a dead body, a licensure investigation, or a child abuse/neglect investigation.

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment, to obtain payment for services we rendered, or for healthcare operations. For example, we may make a referral to or consult with another dentist or other healthcare professional, provide a specimen to a laboratory for testing, or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient: *I consent to your disclosures of my information that you deem necessary in connection with my treatment at your office, treatment of me by another physician or healthcare provider, to obtain payment for services you rendered, or healthcare operations. I understand that such disclosures may not be of the type listed above.*

_____ _____

Patient Signature Patient Name (please print)

_____

Date

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PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Patient Name _____ Patient Phone Number _____

Address _____

Date of Birth _____

I authorize the disclosure and use of health information as described below:

Greater Michigan Oral Surgeons & Dental Implant Center has my permission to disclose any information to the following:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

☐ For Treatment ☐ For Care Coordination ☐ Payment ☐ Other

Information that may be disclosed is as follows:

Entire medical record, which includes appointment information, medical information, entire dental record, discharge information, medication information, medical advice, chemical health records, lab results, allergy list, lab results, X-ray and imaging, and consult reports from doctor/dentist

This authorization will expire on the patient's 18th birthday (if a minor).

_____ _____

Signature of Patient or Patient Representative **Date**

If signed by patient's representative:

_____ _____

Print Representative's Name **Date**

_____ _____

Witness **Date**