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:
_____
☐ Other Mental 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: _____