Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide.
We look forward to working with you to maintain a healthy, happy smile!

Patient Information

Date _____
SS/HIC/ID# _____
Patient Name _____
Last Name _____
First Name _____ **Middle Initial**
E-Mail _____
Address _____
City _____
State _____ **Zip** _____
Sex ☐ M ☐ F **Age** _____
Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ Years

Patient Employer/School _____
Occupation _____
Employer/School Address _____
Employer/School Phone _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom May We Thank For Referring You? _____

Dental Plan Carrier

Who is Responsible for this Account? _____
Relationship to Patient _____
Dental Plan _____
Group # _____
Is Patient Covered by Additional Plan? ☐ Yes ☐ No
Subscriber's Name _____
Birthdate _____ **SS#** _____
Relationship to Patient _____
Dental Plan _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have dental plan coverage with _____ and assign directly to:
Name of Dental Carrier(s)
Dr. _____ all dental benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my dental plan.** I authorize the use of my signature on all dental plan submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Dental Carrier and their agents for the purpose of obtaining payment for services and determining dental carrier or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ **Relationship to Patient** _____

Phone Numbers

Home ( ) _____ Work ( ) _____ Ext. _____ Cell Phone ( ) _____
Spouse Work ( ) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____
Home Phone ( ) _____ Work Phone ( ) _____

Dental History

Reason For Today's Visit _____
Date of Last Thorough Exam _____
Date of Last Full Mouth X-Rays _____
Are You Dissatisfied With Your Teeth In Any Way?
(For Ex.: Color, Shape, Spacing, etc.?) Please Explain:

Are You Interested In Replacing Mercury/Amalgam Fillings? ☐ Yes ☐ No
Would You Prefer To Have A More Natural Tooth Colored Restoration? ☐ Yes ☐ No

Place a mark on "YES" or "NO" to indicate if you have had any of the following:

Burning Sensation on Tongue	☐ Yes	☐ No	Gums Swollen or Tender	☐ Yes	☐ No
Chew on One Side of Mouth	☐ Yes	☐ No	Jaw Pain or Tiredness	☐ Yes	☐ No
Smoke or Chew Tobacco	☐ Yes	☐ No	Lip or Cheek Biting	☐ Yes	☐ No
Clicking or Popping Jaw	☐ Yes	☐ No	Sores or Growths in Your Mouth	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No	Mouth Pain, Brushing	☐ Yes	☐ No
Fingernail Biting	☐ Yes	☐ No	Past Orthodontic Treatment	☐ Yes	☐ No
Food Collection Between Teeth	☐ Yes	☐ No	Pain Around Ear	☐ Yes	☐ No
Grinding Teeth	☐ Yes	☐ No	Past Periodontal Treatment	☐ Yes	☐ No
Mouth Breathing	☐ Yes	☐ No			

How Often Do You Floss? _____
How Often Do You Brush? _____

Turn Page Over For Additional Items →

Dental Registration and History

Health History

Physicians Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "Yes" or "No" to indicate if you have had any of the following (Con't):

Sensitivity to Cold	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Sensitivity to Heat	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Sensitivity to Sweets	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Special Diet/Restrictions	☐ Yes ☐ No
Sensitivity When Biting	☐ Yes ☐ No	Fainting or Dizziness	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bad Breath	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Bleeding Gums	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Blisters on Lips or Mouth	☐ Yes ☐ No	Heart Issues _____	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Loose Teeth or Broken Fillings	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Tonsilitis	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Herpes/Cold Sores	☐ Yes ☐ No	Tuberculosis/TB	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Ulcer/Stomach Issues	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Weight Loss, Unexplained	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Have You Ever Been Told That	
Artificial Joints	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	You **SNORE**?	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Have You Ever Had a Sleep	
Back Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Study Done?	☐ Yes ☐ No
Bleeding Abnormally With Surgery	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Do You Have Sleep Apnea?	☐ Yes ☐ No
Extractions or Surgery	☐ Yes ☐ No	Lupus	☐ Yes ☐ No		
Blood Disease	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	**Other Health Conditions Not Listed:**	
Chemical Dependency	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	_____	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	_____	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No	_____	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	_____	☐ Yes ☐ No
Cough, Persistent or Bloody	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	_____	☐ Yes ☐ No

Women:

Are You Pregnant?	☐ Yes ☐ No Due Date: _____	Are You Nursing?	☐ Yes ☐ No
Taking Birth Control Pills?	☐ Yes ☐ No	Do You Wear Contact Lenses?	☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

PHARMACY NAME: _____

PHONE NUMBER: (_____) _____

Allergies

☐ **Aspirin** ☐ **Local Anesthetic**

☐ **Barbiturates** ☐ **Penicillin**

☐ **Codeine** ☐ **Sulfa**

☐ **Iodine** ☐ **Other** _____

☐ **LATEX** _____

Updates (To Be Filled In At Future Appointments)

Have there been any changes in your health since your last dental appointment? Yes ☐ No ☐

For what Conditions? _____

Are you taking any new medications? ☐ Yes ☐ No If so, what? _____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____

Have there been any changes in your health since your last dental appointment? Yes ☐ No ☐

For what Conditions? _____

Are you taking any new medications? ☐ Yes ☐ No If so, what? _____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____

Advanced Family Dentistry and Dr. Aimee Chisik, D.D.S.

Financial Policy

Thank you for choosing Advanced Family Dentistry and/or Dr. Aimee Chisik, D.D.S. for your care. The doctors and staff are committed to providing quality, affordable Dental care. We sincerely hope that by sharing our financial expectations we will strengthen the practice/patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients.

- **ALL SERVICES RENDERED FROM THIS OFFICE ARE FULLY AND COMPLETELY THE PATIENT'S RESPONSIBILITY FOR THE ENTIRE BALANCE.**

- **INSURANCE:** We participate with many dental plans. As a courtesy, we will bill your Dental Carrier on your behalf; however, **you are ultimately responsible for timely payment of any non-covered services, co-payments and deductibles in full before your next scheduled visit.** If, for any reason you are not able to do this, you must notify our office immediately! Failure to do so in a timely fashion may result in the cancellation of your next appointment or procedure.

  Knowing your dental benefits and coverage limitations is your responsibility. We are happy to assist in coordinating/maximizing your treatment with your existing benefits. **It is your responsibility to notify us of any changes in your address, phone number, employment or dental plan before your appointment.**

- **CO-PAYS are due at the time services are rendered. Co-pays are calculated/based upon the information provided by your Dental Carrier.** These **co-pays are an estimation** and additional money may be due by the patient when the Explanation Of Benefits is received from the Dental Carrier.

Patient balances that go unpaid for 30 days or more may incur the following additional charges:

- **Interest Charges 1.5% per month or 18% APR**
- **Collection Fees**
- **Legal Fees**
- **After 90 days of non-payment all accounts are sent to collections. Patients will be contacted before doing this.**
- **A $50 fee will be applied for any returned checks.**

- **SELF-PAY ACCOUNTS:** If you do not have Dental Coverage, we do offer Care Credit, or 5% for cash. We also accept Mastercard, VISA and Personal Checks, however, your visits must be paid in full before the time of service.

Failure to comply with our financial policy may result in the termination of the patient/doctor relationship, and dismissal from the practice.

Cancellation Policy

For any appointment cancellations or reschedules, we require no less than 24 hours notice. Failure to comply with this may result in a $50 missed appointment fee.

X_____

Signature of Patient/Guardian **Date**

Please keep a copy of your walk out statement and help us by following up with your Dental Plan to ensure payment is in process.

ADVANCED FAMILY DENTISTRY
Dr. David Towne, D.D.S.
Dr. Aimee B. Chisik, D.D.S.
44644 Ann Arbor Road, Suite F
Plymouth, MI 48170

ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices from this practice.

I understand that the practice routinely confirms appointments and reminders about, pre-medication and may leave messages on an answering machine, voice mail, E-Mail, postcards, or with another family member.

WITNESSES:

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Names of Minor Children:

_____ _____

_____ _____

_____ _____