

ABSOLUTE DENTAL

Gentle care for the entire family
 18014 Wolf Rd.
 Orland Park, IL 60467
 708-326-1175

PLEASE COMPLETE AND RETURN TO BUSINESS OFFICE

Personal Information

Name	Last	First	Middle
Address	Street or P.O. Box#	City	State Zip Code Home Phone:
Work Phone:	Cell Phone:	Email Address:	
Birth Date	Mo. Day Year	() Married () Single () Divorced	

Insurance Information

Insured Person's Full Name	Date of Birth	
Social Security Number	Relationship to Patient	Work Phone
Insurance Company Name	Group or Union Name	Group or Local Number
Employer's Name	Full Address of Employer	

Getting to Know You

1. What brings you to our practice today? _____	4. Person to contact for emergency: _____ Phone: _____
2. Whom may we thank for referring you? _____	5. When was your last dental visit? _____
3. Is another member of your family or relative a patient on our practice? _____	6. When was the last time you had complete dental xrays taken? _____
	Name & Address of last Dentist: _____

Payments Alternatives

Please check appropriate box.

<input type="checkbox"/> 1. As a special service to you, we offer a cash courtesy if you pay your entire treatment plan in full, in advance.	This means that you are responsible for your deductible and the portion the insurance does not cover. Remember, however, that you are responsible for the account if the insurance company, for any reason, does not honor their commitment to you and to us.
<input type="checkbox"/> 2. Cash and personal checks are accepted as your treatments are provided.	
<input type="checkbox"/> 3. If you have dental insurance, we want you to receive the full benefit of it. Our office team can assist you in completing your insurance forms and verifying the coverage that your particular program provides. We accept assignment of your insurance payment, another service to you.	
<input type="checkbox"/> 4. Mastercard, Visa, Discover and American Express	
<input type="checkbox"/> 5. For long term or extended payments we offer a healthcare financing program, which when you are accepted, will allow extended small monthly payments for the treatment received.	

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he and she deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or team. I agree to pay all services rendered by this office.

Signature of Responsible Party _____ Relationship _____ Date _____

MEDICAL HISTORY

1. If you could change anything about your smile, what would you change? _____
2. Rate your smile 1-10: _____
3. Do your gums bleed at any time?..... Yes No
4. Do you feel uncomfortable about having dental treatment?..... Yes No
5. Have you ever had an unpleasant experience in the dental office? Yes No
6. Have you been under the care of a medical doctor during the past two years?..... Yes No

If yes, for what reason? _____

Please provide the name, address, and telephone number of your physician.

7. Have you been a patient in the hospital during the past two years?..... Yes No
If yes, for what reason? _____
8. Have you taken any medicine or drugs during the past two years? If yes, please list:
(include herbs, vitamins, etc.)..... Yes No

9. Check any of the following which apply in either past or present:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Surgery/Disease | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pain In Jaw Joints |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heavy Snoring | <input type="checkbox"/> X-Ray or Cobalt Treatment |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Cancer or Tumors |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Joint of Any Type | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Diet Medication: Name _____ | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> HIV Positive (AIDS) |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Any Form of Eating Disorder | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Recreational Drug Use | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Drug Addiction / Alcoholism | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Any Form of Hepatitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Birth Control Medication |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Pregnant - weeks/month _____ |

10. Are you allergic to or made sick by penicillin, latex, aspirin, codeine, or any drugs or medicines,
(i.e., itching, rash, swelling of hands, feet or eyes)? If yes, please list Yes No
11. Do you have any disease, condition or problem not listed? If so, please list..... Yes No

Signature of Responsible Party

Relationship

Date