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?

2. Whom may we thank for referring you?

3. Is another member of your family or relative a patient on our practice?

4. Person to contact for emergency: _____
   Phone: _____
5. When was your last dental visit? _____
6. When was the last time you had complete dental xrays taken?

   Name & Address of last Dentist:

Payments Alternatives

Please check appropriate box.

- ☐ 1. As a special service to you, we offer a cash courtesy if you pay your entire treatment plan in full, in advance.
- ☐ 2. Cash and personal checks are accepted as your treatments are provided.
- ☐ 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. 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.
- ☐ 4. Mastercard, Visa, Discover and American Express
- ☐ 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 _____

FORM 009809 N/03/09 ITEM 8101

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:

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