



All Heart

DENTAL

Natalie Korolis D.M.D.

7804 College Drive
Suite 2 Northwest
Palos Heights, Illinois 60463
708.448.0400
708.671.8457

Demographics

Last Name: _____ First Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Email: _____

Medical History

Name of Physician: _____
Address of Physician's Office: _____ City: _____ State: _____ Zip: _____
Date of Last Physical Exam: _____

Do you have or have you ever had any of the following disease or medical conditions:

Anemia/Bleeding Problems	Yes	No	High/Low Blood Pressure	Yes	No	Tuberculosis	Yes	No
Arthritis/ Rheumatism/Gout	Yes	No	Hepatitis A/B/C (Circle One)	Yes	No	Tumors	Yes	No
Artificial Joints/Bones	Yes	No	Herpes	Yes	No	Ulcers	Yes	No
Asthma	Yes	No	Kidney Disease	Yes	No			
AIDS/HIV	Yes	No	Liver Disease	Yes	No			
Blood Disease	Yes	No	Nervous Disease	Yes	No			
Cancer	Yes	No	Nursing	Yes	No			
Chemotherapy	Yes	No	Pacemaker	Yes	No			
Congenital Heart Lesions	Yes	No	Pregnant	Yes	No			
Diabetes	Yes	No	Psychiatric Care	Yes	No			
Emphysema	Yes	No	Radiation Treatment	Yes	No			
Epilepsy	Yes	No	Shortness of Breath	Yes	No			
Fainting/ Dizziness	Yes	No	Sinus Trouble	Yes	No			
Glaucoma	Yes	No	Stroke	Yes	No			
Headaches (Frequent)	Yes	No	Thyroid Problems	Yes	No			

List any allergies:

List Any Other Medical Issues You Have:

List Any Medications You Are Taking:

Any Serious Illness/Surgeries/Hospitalization:



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Dental History

Reason for visit: _____

Date of last dental visit: _____ Date of last dental xrays: _____

How often do you floss: _____ How often do you brush: _____

Circle Any That Apply:

Bad Breath	Yes	No	Grinding Teeth	Yes	No
Bleeding, Red, Swollen Gums	Yes	No	Pain around ear/side of face	Yes	No
Broken/Loose Teeth or Fillings	Yes	No	Cold Sores/ Sores in Mouth	Yes	No
Clicking/Popping Jaw	Yes	No	Sensitivity	Yes	No
I would like my teeth to be whiter	Yes	No			

Dental Insurance Information

Primary Insurance

Insurance Company Name: _____

Subscribers Name: _____ Date of birth: _____

Social Security Number: _____ Subscriber ID: _____

Group Number: _____ Employer: _____

Secondary Insurance

Insurance Company Name: _____

Subscribers Name: _____ Date of birth: _____

Social Security Number: _____ Subscriber ID: _____

Group Number: _____ Employer: _____

Authorization, Release & Agreement to Pay for Services Rendered

I authorize All Heart Dental to release any information requested by my insurance carrier, third party payor or health practitioner. I understand my insurance is an agreement between me and my insurance company and that I am ultimately responsible for payment for services rendered by the doctors and staff at All Heart Dental. I understand it is my responsibility to ensure that my dentist has met my insurance carrier's requirements, if any, to render treatment. I authorize payment directly to All Heart Dental. I authorize All Heart Dental to act as my agent to help me obtain payment from my insurance company. This authorization will remain in effect until revoked by me in writing. **Payment in full (or deductibles and co-payment for patients with dental insurance) is expected at each appointment.**

For your convenience, we offer the following methods of payment: Cash, Personal Check, MasterCard, VISA, AMEX & Discover

If you have any questions concerning fees and financial obligations, it will be our pleasure to assist you. I understand that billing/finance charges will be added to the unpaid balance of my account after 90 days. I hereby acknowledge that I have read and understood All Heart Dental. Notice of Privacy Practices, have obtained a copy upon request and will receive a copy of any amendments upon request.

Signature of Patient/Responsible Party

Date