



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: _____

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: _____



All Heart

DENTAL

Natalie Korolis D.M.D.

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

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			

Has the patient had any problem with dental treatment in the past? Yes No

If yes, please describe what happened: _____

Has the patient had any problems with teeth coming in or losing teeth? Yes No

Does the patient use fluoride toothpaste when brushing teeth? Yes No

Has the patient ever worn braces or other orthodontic appliances? Yes No

Has the patient ever had a serious injury to the head, mouth or teeth? Yes No

If yes, please describe what happened and when it happened: _____

Does the patient play any contact sports or participate in active recreational activities? Yes No

If yes, please describe those activities here: _____

Is your home water supply fluoridated? Yes No

What is the patient's primary source of drinking water? Tap Bottled Filtered Well

Does the patient take fluoride supplements? Yes No

Does/did the patient use a pacifier or suck his/her thumb or fingers? Yes No

At what age did the patient stop breast feeding? _____

At what age did the patient stop bottle feeding? _____

Has the patient ever experienced any sleep-related breathing disorders such as mouth breathing or snoring trouble breathing during sleep? Yes No

Does the patient have any speech difficulties? Yes No

If yes, please explain. How would you describe the patient's eating habits? _____

Is the patient up-to-date with immunizations (tetanus, measles, mumps, etc)? 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: _____



All Heart

DENTAL

Natalie Korolis D.M.D.

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

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

Notice: X-rays and Insurance Coverage

We will recommend that certain x-rays be taken on a periodic basis as they may provide important diagnostic information to detect early stages of decay and other oral diseases. Each insurance policy varies on coverage of x-rays, and the x-rays we recommend may not be covered by your insurance policy. We encourage you to know and be aware of the x-ray policy of your insurance carrier. If you should choose to decline having x-rays taken that we recommend for you, please notify us.

I understand the above information and agree with its contents.

Signature of Patient/Responsible Party

Date

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have designed an Appointment Cancellation Policy. This policy will allow us to schedule appointments with confidence and security to better serve you. When an appointment is scheduled, that time has been set aside for you. When that appointment is cancelled same day, or with too short of notice, that time cannot be used to treat another patient since it is customized to your oral health needs.

We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows our staff to offer that appointment time to other patients in need. If you miss an appointment without contacting our office, within the required time, this is considered a missed/failed appointment. A **fee of \$50.00 will** be charged to your account for same day cancellation; this fee cannot be billed to your insurance company and will be your direct responsibility. Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **\$50.00 cancellation fee** will be charged.

We thank you kindly for your understanding and cooperation. I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its' terms. I also understand and agree that such terms may be amended from time-to-time by the All Heart Dental.

Signature of Patient/Responsible Party

Date