Orthodontics
Matthew Ahrens, DMD
Mary Shehata, DDS

General Dentistry
Michael Chiaramonte, DMD
Kara Ford, DMD
Justin Mitchell, DMD
Rebecca Warnken, DDS

Pediatrics
Eva Dupay, DMD, MSD
James McIlwain, DDS, MSD
Leigh Ann McIlwain, DMD
Michael McIlwain, DMD

PATIENT REGISTRATION

MEDICAL AND DENTAL HISTORY

Child's Name ______________________________
Male or Female ______________________________
Child Nickname ______________________________
Date of Birth ____________________ Age _______
Pediatrician ______________________________
Pediatrician's Phone # ______________________________
Who may we thank for referring you? ______________________________

RESPONSIBLE PARTY INFORMATION

Name ____________________ Date of Birth ________
Relationship to Patient ______________________________
Address ______________________________
City ____________________ State ________ Zip________
Phone ____________________ E-mail ____________________
Primary Insurance Carrier ______________________________
Member Name ______________________________
Employer ____________________ Group #______________
Member ID ______________________________

Name ____________________ Date of Birth ________
Relationship to Patient ______________________________
Address ______________________________
City ____________________ State ________ Zip________
Phone ____________________ E-mail ____________________
Primary Insurance Carrier ______________________________
Member Name ______________________________
Employer ____________________ Group #______________
Member ID ______________________________

MEDICAL HISTORY

Has your child experienced any of the following?

Heart condition, murmur.......... ☐Yes ☐No
Hypertension, high blood pressure.......... ☐Yes ☐No
Rheumatic fever.......... ☐Yes ☐No
Bleeding problems, hemophilia.......... ☐Yes ☐No
Diabetes.......... ☐Yes ☐No
Anemia.......... ☐Yes ☐No
Sickle cell anemia.......... ☐Yes ☐No
Asthma, lung disease, or breathing problems.......... ☐Yes ☐No
Liver disease, jaundice, hepatitis.......... ☐Yes ☐No
Thyroid or glandular/endocrine problems.......... ☐Yes ☐No
Kidney disease.......... ☐Yes ☐No
Arthritis, auto-immune or connective tissue diseases.......... ☐Yes ☐No
Cancer, tumor, leukemia.......... ☐Yes ☐No
Seizures, epilepsy.......... ☐Yes ☐No
Fainting spells.......... ☐Yes ☐No
Frequent headaches.......... ☐Yes ☐No
Frequent infections.......... ☐Yes ☐No
Eye disease.......... ☐Yes ☐No
Ear infections.......... ☐Yes ☐No
Hearing loss or impairment.......... ☐Yes ☐No
Congenital birth defects.......... ☐Yes ☐No
Cerebral palsy.......... ☐Yes ☐No
Cleft lip/ palate.......... ☐Yes ☐No
Developmentally delayed.......... ☐Yes ☐No
Delayed speech development.......... ☐Yes ☐No
Autism.......... ☐Yes ☐No
ADHD/behavioral or learning problems.......... ☐Yes ☐No
AIDS, HIV positive.......... ☐Yes ☐No
Psychiatric problems.......... ☐Yes ☐No

If you answer yes to any of these, please explain: ______________________________
____

Please list any medications, vitamins or health supplements your child is currently taking: ______________________________
____

Please list any hospitalizations or surgeries: ______________________________

Are you on a special diet? ☐Yes ☐No | **Do you use tobacco?** ☐Yes ☐No | **Do you use controlled substances?** ☐Yes ☐No

If you answer yes to any of these, please explain: ______________________________

ALLERGIES

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐ Latex ☐Sulfa drugs ☐Other

Please list any other food or medication allergies: ____

____

DENTAL HISTORY

Do you have a dental related concern? ☐Yes ☐No

If you answer yes to any of these, please explain: ____

____

Is your child experiencing any of the following?

TMJ/TMD Problems.. ☐Yes ☐No
Reaction to Sedative.. ☐Yes ☐No
Grinding.. ☐Yes ☐No
Problems Sleeping at Night................................. ☐Yes ☐No
Snoring... ☐Yes ☐No
Thumb, Finger, Pacifier Use...................................... ☐Yes ☐No
Currently Using Bottle or Sippy Cup.......................... ☐Yes ☐No
Currently Nursing.. ☐Yes ☐No
Trouble Breastfeeding at Birth.................................. ☐Yes ☐No

Please complete the following questionnaire as thoroughly as possible. The information will be valuable assistance to us in establishing meaningful communication with your child.

1. How do you expect your child will respond to dental treatment: ____

____

____

____

2. Favorite hobbies, games: ____
3. Does your child have any pets? ____
4. Names of brothers and sisters: ____
5. School and grade: ____

Consent
The signature affixed below authorizes examination and treatment by the dentists, and/or their staff, and further, use of those procedures which in the judgment of the doctor are necessary during the delivery of dental care.

Insurance Information
I understand that McIlwain Dental Specialists may not be a contracted provider for my insurance company and that MDS will be filing to my insurance company as a courtesy and expect their payment in 30 days. I recognize that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by the insurance company.

I hereby assign all dental and/or surgical benefits to include the major medical benefits to which I am entitled, including private insurance and other health plans to McIlwain Dental Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize and assign to release all information necessary to secure payment.

Authorization and Release
I certify that the above questions have been accurately answered and the information is correct to the best of my knowledge. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patients Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operation. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in regards to your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Individuals to whom information may be given regarding your dental records:

1. ____
2. ____
3. ____

____ ______________________

Signature Date

Financial Policy
Thank you for choosing McIlwain Dental Specialists. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS You can choose from:
- Cash, Check, Visa or MasterCard, American Express, Discover Card, In-office payment plans with no interest.
- NO INTEREST Payment Plans from CareCredit
    - Allow you to pay over time with NO INTEREST
    - Convenient, low monthly payment plans also available
    - No annual fees or pre-payment penalties

Please note:
- Payment is due in full at the time services are rendered.
- In cases of divorce or separation, **the parent that brings the child for an appointment is responsible for payment.**
- For sedation appointments, a $300 deposit is required to secure your treatment appointment.
- For patients with dental insurance, we are happy to work with your carrier to maximize your benefits. At the time of treatment, we will collect your estimated portion and directly bill your insurance carrier for services. However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
- Our office charges $30 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

______________________________________ ____________________

Patient or Guardian Signature Date

____

Patient Name (Please Print)

302 N. Howard Ave.
Tampa, FL, 33606
(813) 879-8097

26908 Foggy Creek Road, Suite 101
Wesley Chapel, FL 33544
(813) 991-9893