Orthodontics
Matthew Ahrens, DMD
Mary Shehata, DDS

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

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

MEDICAL HISTORY FORM

Name_____ SS#_____ Birth Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-mail_____

Emergency Contact_____ Phone_____

Person Responsible for Payment_____

Primary Insurance Carrier_____ Group Number_____ Member ID_____

Member Name_____ Date of Birth_____ Employer_____

Secondary Insurance Carrier_____ Group Number_____ Member ID_____

Member Name_____ Date of Birth_____ Employer_____

Are you under a physicians care now? ☐Yes ☐No

If yes, please explain _____

*Name of physician*_____

Have you had a serious illness, operation, or hospitalization in the past 5 years? ☐Yes ☐No

If yes, please explain _____

Are you on a special diet? ☐Yes ☐No *If yes, please explain* _____

Do you have, or have you had any of the following?

Cardiovascular disease ☐Yes ☐No
Angina ☐Yes ☐No
Arteriosclerosis ☐Yes ☐No
Congestive heart disorder ☐Yes ☐No
Damaged/artificial heart valves ☐Yes ☐No
Heart attack ☐Yes ☐No
Heart murmur ☐Yes ☐No
Low blood pressure ☐Yes ☐No
High blood pressure ☐Yes ☐No
Congenital heart defects ☐Yes ☐No
Mitral valve prolapse ☐Yes ☐No
Irregular heartbeat ☐Yes ☐No
Pacemaker ☐Yes ☐No
Rheumatic fever/scarlet fever ☐Yes ☐No
Stroke ☐Yes ☐No
Blood disease ☐Yes ☐No
Abnormal/excessive bleeding ☐Yes ☐No
Anemia ☐Yes ☐No
Blood transfusion ☐Yes ☐No
Bruise easily ☐Yes ☐No

Hemophilia ☐Yes ☐No
Breathing difficulty ☐Yes ☐No
Sinus trouble ☐Yes ☐No
Asthma ☐Yes ☐No
Emphysema ☐Yes ☐No
Lung disease ☐Yes ☐No
Tuberculosis ☐Yes ☐No
Frequent cough ☐Yes ☐No
Anaphylaxis ☐Yes ☐No
Liver disease ☐Yes ☐No
Yellow jaundice ☐Yes ☐No
Renal dialysis ☐Yes ☐No
Thyroid disease ☐Yes ☐No
Stomach/intestinal disease ☐Yes ☐No
Ulcers ☐Yes ☐No
Kidney problems ☐Yes ☐No
Osteoporosis ☐Yes ☐No
Arthritis/gout ☐Yes ☐No
Artificial joint ☐Yes ☐No
Rheumatism ☐Yes ☐No

Spina Bifida ☐Yes ☐No
Hepatitis A ☐Yes ☐No
Hepatitis B or C ☐Yes ☐No
Shingles ☐Yes ☐No
Parathyroid disease ☐Yes ☐No
Cancer ☐Yes ☐No
Leukemia ☐Yes ☐No
Chemo treatment ☐Yes ☐No
Radiation therapy ☐Yes ☐No
Tumors or growths ☐Yes ☐No
Recent weight loss ☐Yes ☐No
Alzheimer's disease ☐Yes ☐No
Epilepsy of Seizures ☐Yes ☐No
Convulsions ☐Yes ☐No
Fainting spells/dizziness ☐Yes ☐No
Diabetes ☐Yes ☐No
Aids/ HIV positive ☐Yes ☐No
Sexually transmitted disease ☐Yes ☐No
Drug addiction ☐Yes ☐No
Psychiatric care ☐Yes ☐No

Do you have a disease or condition not listed above? ☐Yes ☐No *If yes, please explain* _____

Women, are you..

Pregnant/Trying to get pregnant? ☐Yes ☐No **Taking oral contraceptives?** ☐Yes ☐No **Nursing?** ☐Yes ☐No

ALLERGIES

Are you allergic or have you had a reaction to any of the following? If yes, specify type of reaction.

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

☐Other *If yes, please explain* _____

MEDICATION

Do you take or have you taken Fosamax, Boniva, Actonel, or any other medications containing Bisphosphonates?
☐Yes ☐No

Are you taking a blood thinner or daily Aspirin? ☐Yes ☐No

Do you use tobacco? ☐Yes ☐No

Are you using a controlled substance? ☐Yes ☐No

Do you take a cortisone medication? ☐Yes ☐No

Are you taking any prescription or over-the-counter medication? ☐Yes ☐No

Please list all medications you are currently taking _____

_____

DENTAL

When was your last dental exam and cleaning? _____

Do you have a history of orthodontic treatment? ☐Yes ☐No

If yes, please explain _____

Are you happy with the way your teeth look? If no, what would you like to improve? ☐Yes ☐No

If not, please explain _____

Do you clench or grind your teeth? ☐Yes ☐No

If yes, please explain _____

Do you have a history of TMJ/ jaw joint pain? ☐Yes ☐No

If yes, please explain _____

Do you have any dental concerns? ☐Yes ☐No

If yes, please explain _____

Do you have any cold sores or blisters? ☐Yes ☐No

If yes, please explain _____

I certify the questions on this form have been accurately answered. I understand the importance of a truthful health history and the dentist and his/her staff will rely on this information for treating me.

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

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)

4710 N. Habana Ave. Suites 203 – 207
Tampa, FL 33614
(813) 879-8097

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