



Orthodontics
Matthew Ahrens, DMD
Mary Awadallah, DDS

General Dentistry
Justin Mitchell, DMD
Rebecca Warnken, DDS

Children's Dentistry
Kara Ford, DMD
Jerry Copeland, 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 <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Angina <input type="checkbox"/> Yes <input type="checkbox"/> No | Breathing difficulty <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congestive heart disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Damaged/artificial heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Parathyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent cough <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemo treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation therapy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors or growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Yellow jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No | Renal dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No | Alzheimer's disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy of Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rheumatic fever/scarlet fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach/intestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting spells/dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abnormal/excessive bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Aids/ HIV positive <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis/gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial joint <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug addiction <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise easily <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric care <input type="checkbox"/> Yes <input type="checkbox"/> 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

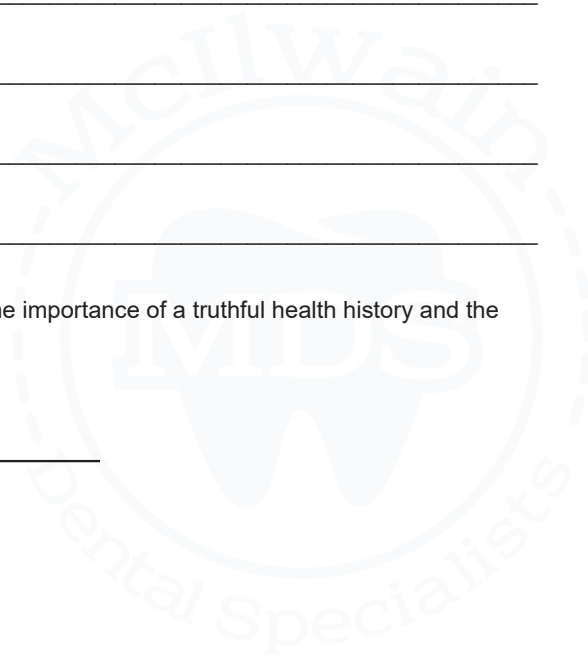
If yes, please explain _____

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:

- _____
- _____
- _____

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 North Howard Avenue
Tampa, FL 33606
(813) 879-8097

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

