



McILWAIN DENTISTRY

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Patient Information (CONFIDENTIAL) _____ Date _____

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____ Full Time Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You to This Office? _____

Emergency Contact _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ Soc. Sec. # _____

Employer _____ Work Phone _____

Insurance Information

I understand that McIlwain Dentistry is not a contracted provider for my insurance company and that MD will be filing to my insurance company as a courtesy and expect their payment on 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 major medical benefits to which I am entitled, including private insurance and other health plans to: **McIlwain Dentistry, Inc.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as and original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assigns to release all information necessary to secure the 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 operations. 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 and issues:

1. _____
2. _____
3. _____

Signature _____ Date _____ SSN _____

PATIENT REGISTRATION

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you having any dental concerns? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain. _____ | | | If yes, what? _____ | | |
| 2. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you allergic to or had any reaction to the following: | | |
| If yes, for what? _____ | | | Local anesthetic | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been hospitalized for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other antibiotic | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, for what? _____ | | | Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you taking any medication? | <input type="checkbox"/> | <input type="checkbox"/> | Barbituates | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list medication and dosage | | | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | Any metals (nickel, mercury) | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | Latex rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco products? | <input type="checkbox"/> | <input type="checkbox"/> | Please list any other allergies _____ | | |
| If yes, what and frequency? _____ | | | _____ | | |
| 6. Do you use alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Women Only: | | |
| If yes, how often? _____ | | | Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | YES | NO | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| high or low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | recent weight loss | <input type="checkbox"/> | <input type="checkbox"/> |
| heart attack | <input type="checkbox"/> | <input type="checkbox"/> | emphysema | <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV infection | <input type="checkbox"/> | <input type="checkbox"/> |
| heart disease | <input type="checkbox"/> | <input type="checkbox"/> | asthma | <input type="checkbox"/> | <input type="checkbox"/> | sexually transmitted disease | <input type="checkbox"/> | <input type="checkbox"/> |
| cardiac pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | under psychiatric care | <input type="checkbox"/> | <input type="checkbox"/> | anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| angina | <input type="checkbox"/> | <input type="checkbox"/> | fainting / seizures | <input type="checkbox"/> | <input type="checkbox"/> | leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| heart murmur or prolapse mitral valve ... | <input type="checkbox"/> | <input type="checkbox"/> | epilepsy / convulsions | <input type="checkbox"/> | <input type="checkbox"/> | hayfever / allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| prosthetic heart valve / shunt | <input type="checkbox"/> | <input type="checkbox"/> | diabetes | <input type="checkbox"/> | <input type="checkbox"/> | arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | family history of diabetes | <input type="checkbox"/> | <input type="checkbox"/> | osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| swollen ankles | <input type="checkbox"/> | <input type="checkbox"/> | kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| chest pains | <input type="checkbox"/> | <input type="checkbox"/> | thyroid disorder | <input type="checkbox"/> | <input type="checkbox"/> | radiation therapy / chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| easily winded | <input type="checkbox"/> | <input type="checkbox"/> | hepatitis / jaundice | <input type="checkbox"/> | <input type="checkbox"/> | glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| stroke | <input type="checkbox"/> | <input type="checkbox"/> | stomach trouble / ulcers | <input type="checkbox"/> | <input type="checkbox"/> | joint replacement or implant | <input type="checkbox"/> | <input type="checkbox"/> |
| respiratory problems | <input type="checkbox"/> | <input type="checkbox"/> | liver disease | <input type="checkbox"/> | <input type="checkbox"/> | history of organ transplant | <input type="checkbox"/> | <input type="checkbox"/> |

Other _____

Please explain any yes answers _____
