



# Patient Medical Dental History

McILWAIN DENTISTRY

James E. McIlwain, DDS, MSD  
Leigh Ann McIlwain, DMD  
Michael F. McIlwain, DMD

Child's Name  Male  Female

Child's Nickname Date of Birth

Pediatrician Pediatrician's Phone Number

Who may we thank for referring you?

**Has your child experienced any of the following?:**

	Yes	No		Yes	No
Autism .....	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice, Liver Disease, Hepatitis .....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, Lung Disease or Breathing Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections, Hearing Loss or Impairment .....	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems, Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>	Special Needs, Mentally Handicapped .....	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy .....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems .....	<input type="checkbox"/>	<input type="checkbox"/>
Cleft Lip / Palate .....	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>
Delayed Speech Development .....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>
Developmentally Delayed .....	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches, TMJ Problems, TMD .....	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid or Glandular / Endocrine Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Birth Defects .....	<input type="checkbox"/>	<input type="checkbox"/>
ADHD / Behavioral or Learning Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Auto-Immune or Connective Tissue Diseases ...	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells .....	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS, HIV Positive .....	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to Medication .....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition, Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Thumb / Finger / Pacifier Habit .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Tumor, Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Problems Sleeping at Night .....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Infections .....	<input type="checkbox"/>	<input type="checkbox"/>	Snoring .....	<input type="checkbox"/>	<input type="checkbox"/>
Eye Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Currently Using Bottle or Sippy Cup .....	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension, High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Currently Nursing .....	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any yes answers:

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

\_\_\_\_\_

\_\_\_\_\_

**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. Will your child be a cooperative patient? Explain: \_\_\_\_\_
2. Favorite hobbies, games \_\_\_\_\_
3. Does your child have any pets? \_\_\_\_\_
4. Names of brothers and sisters \_\_\_\_\_
5. School and grade \_\_\_\_\_

**PATIENT REGISTRATION**

**Responsible Party Information**

Name _____	Spouse's Name _____
Address _____	Address (if different) _____
City _____ State _____	City _____ State _____
Zip _____ Phone _____	Zip _____ Phone _____
E-mail _____ Cell _____	E-mail _____ Cell _____
Employer _____	Employer _____
Employer's Address _____	Employer's Address _____
City _____ State _____	City _____ State _____
Zip _____ Phone _____	Zip _____ Phone _____
Date of Birth _____	Date of Birth _____
Social Security No. _____	Social Security No. _____
Driver's License No. _____	Driver's License No. _____

**Consent**

*The signature affixed below authorizes examination and treatment by Dr. James E. McIlwain, Dr. Leigh Ann McIlwain, and/or Dr. Michael F. McIlwain and their staff, and further, use of those procedures which in the judgement of the doctor are necessary during the delivery of dental care.*

*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 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 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 an 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.*

*Our **Notice of Privacy Practices** provides information about how we 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.*

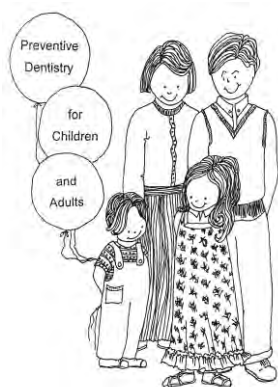
*You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment , or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.*

*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:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

<b>Signature</b> _____	<b>Date</b> _____	<b>SS#</b> _____
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## McIlwain & Chiaramonte Dentistry

James E. McIlwain, DDS, MSD  
Leigh Ann McIlwain, DMD  
Michael N. Chiaramonte, DMD  
Michael F. McIlwain, DMD

### ABOUT DENTAL INSURANCE

**Our office is not a contracted provider with your insurance company. All claims from our office are paid according to your plan's out-of-network coverage. Please check with your insurance company to see if your plan has out-of-network benefits.**

The fees charged for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Your policy may base its allowances on a **fixed fee schedule**, which may or may not coincide with our usual fees. Please keep in mind that dental benefits and allowable fees are determined by your employer and the insurance provider.

Because your insurance policy is a legal agreement between you and your insurance company, all patients are directly responsible for all charges. Ideally and legally, your insurance company reimburses you for dental expenses. As a courtesy service to you, we will complete all forms pertaining to your treatment and send them promptly to your insurance company.

The amount that we estimate your insurance will cover for any procedure is **only an estimate**. We will be happy to send in a pre determination of benefits to your insurance company if you would like to know what your insurance reimbursement will be before care is started.

In our experience, it is not realistic to expect the insurance company to cover all services, irrespective of the premium the patient may be paying. It is our goal to help you obtain the insurance coverage to which you are entitled. We will be happy to work with you in coordinating your insurance benefits, but please remember, **it is the insurance company that dictates your coverage, not our dental office.**

We require insurance deductibles and/or co-payments to be paid at the time of treatment, but for your convenience, will process your insurance claims to help you receive your insurance benefits.

Please feel free to ask questions. Our practice has been built on education, communication, integrity and sincerity.

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I have read and understand the Insurance Policies of McIlwain & Chiaramonte Dentistry

# MCILWAIN & CHIARAMONTE

## Financial Policy

Thank you for choosing McIlwain & Chiaramonte Dentistry. 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
- NO INTEREST Payment Plans from Chase Health Advance and CareCredit
  - o Allow you to pay over time with NO INTEREST
  - o Convenient, low monthly payment plans also available
  - o 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 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
- Our office will only file for primary insurance coverage. If you have secondary insurance, we will gladly give you all necessary paperwork to file with your secondary carrier for reimbursement once your primary carrier has paid.
- A fee of \$50 is charged for patients who miss or cancel more than 1 time in a calendar year without 24-hour notice.
- McIlwain & Chiaramonte Dentistry 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.

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Patient, Parent or Guardian Signature

Date

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Patient Name (Please Print)