

WELCOME

Patient's Name _____

Date of Birth _____

How you wish to be addressed _____

Single__ Married__ Divorced__ Widowed__ Minor__

Address _____

City _____ State _____ Zip _____

Employer _____

Address _____

City _____ State _____ Zip _____

Position _____ How Long? _____

Telephone Home _____

Business _____ Cell _____

Email _____

Patient SSN _____ - _____ - _____

Driver's License No. _____ State _____

Spouse/Parent Name _____

Employer _____

Address _____

City _____ State _____ Zip _____

Position _____ How Long? _____

Spouse/Parent SSN _____ - _____ - _____

Emergency Contact _____

Home Telephone # _____

Cell # _____

Purpose of first Visit _____

Other Family Members in Practice _____

Whom may we thank for this referral _____?

Who is responsible for this account?

Method of Payment Cash ___ CC/Debit ___ Check ___

Dental Insurance Coverage

Subscriber Name _____

Subscriber DOB _____

Employer of Insured _____

Name of Ins Co. _____

Address _____

City _____ State _____ Zip _____

Dental Insurance Coverage

Relationship of Patient to Subscriber _____

Telephone# of Ins. Co. _____

Policy # _____

Group # _____

ID # or SSN # _____

I consent to the diagnostic procedures and treatment necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's) to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of my Records shall be in effect until I revoke it in writing.

I attest to the accuracy of the information I have provided on this page.

Patient or Guardian Signature

Date

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W. Carl McMillan, DMD

218 Ashville Ave Suite 30

Cary, NC 27518

919-865-0700

Patient's Name _____ /_____/_____
Last First MI Date of Birth

COMMENTS: OFFICE USE

- 1. Reason for today's visit _____
- 2. Are you aware of any problem? _____
- 3. How long since your last dental visit? _____
- 4. What was done at that time? _____
- 5. Previous Dentist's Name: _____
- 6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

- 7. Have you made regular dental visits?.....YES / NO
- 8. Were dental x-rays taken?.....YES / NO
- 9. Have you lost any teeth or have any teeth been removed?.....YES / NO
Why? _____
- 10. Have they been replaced?.....YES / NO
- 11. How have they been replaced?
 - a. Fixed Bridge _____ When? _____
 - b. Removable Bridge _____ When? _____
 - c. Denture _____ When? _____
 - d. Implant _____ When? _____
- 12. Are you happy with the replacement?YES / NO
If not, explain _____
- 13. Would you like to know about permanent replacements?YES / NO
- 14. Have you ever had any problems or complications with previous dental treatment?

- 15. Do you clench or grind your teeth?.....YES / NO
- 16. Does your jaw pop or click?YES / NO
- 17. Have you experienced any pain or soreness in the muscles in your face or around your ear?.....YES / NO
- 18. Do you have frequent headaches, neckaches or shoulder aches?.....YES / NO
- 19. Does food get caught in your teeth?.....YES / NO
- 20. Are any of your teeth sensitive to: HOT? COLD? SWEETS? PRESSURE ?
- 21. Do your gums bleed or hurt? When? _____ YES / NO
- 22. Have you ever had gum treatment or surgery?.....YES / NO
What? _____
Where? _____
When? _____
- 23. Do you feel your breath is offensive at times?.....YES / NO
- 24. How often do you brush your teeth daily? 1X 2X 3X More When? _____
- 25. Do you use dental floss?.....YES / NO
How often? _____
- 26. Are any of your teeth: Loose? Tipped? Shifted? Chipped?
- 27. Are you happy with the appearance of your teeth?.....YES / NO
- 28. How do you feel about your teeth in general? _____
- 29. Have you had orthodontic work?.....YES / NO
- 30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
- 31. Do you have any questions or concerns?.....YES / NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE _____ **DATE** _____

DENTIST'S SIGNATURE _____ **DATE** _____

Patient's Name _____ / _____ / _____
Last First MI Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

1. Physician's Name: _____
Address: _____
2. Are you under a physician's care?.....YES / NO
Since when? _____ For What? _____
3. When was your last complete physical exam? _____
4. Are you taking any medication or substances? (please list on reverse side) YES / NO
5. Do you routinely take health related substances? (vitamin, herbal supplements, natural products)? .YES / NO
6. Are you allergic to any medications or substances? (please list on reverse side)..... YES / NO
7. Do you have any other allergies or hives?.....YES / NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications?.....YES / NO
9. Are you sensitive to any metals or latex?.....YES / NO
10. Are you pregnant or suspect you may be?.....YES / NO
11. Do you use any birth control medications?..... YES / NO
12. Have you ever been treated for or been told you might have heart disease?.....YES / NO
13. Do you have a pacemaker, an artificial heart valve, implant or been diagnosed with mitral valve prolapse? YES / NO
14. Have you ever had rheumatic fever resulting in rheumatic heart disease?..... YES / NO
15. Are you aware of any heart murmurs? YES / NO
16. Do you have blood pressure problems? YES / NO
17. Have you ever had a serious illness or major surgery? (Detail on reverse side or separate paper) .YES / NO
18. Have you ever had radiation treatment or chemotherapy for a tumor, growth or other condition?... YES / NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism?.....YES / NO
20. Do you have any artificial joints or prostheses?..... YES / NO
21. Do you have any blood disorders such as anemia, leukemia, etc.?..... YES / NO
22. Have you ever bled excessively after being cut or injured?.....YES / NO
23. Do you have any stomach problems?.....YES / NO
24. Do you have any kidney problems?.....YES / NO
25. Do you have any liver problems?..... YES / NO
26. Are you diabetic?.....YES / NO
27. Do you have fainting or dizzy spells?..... YES / NO
28. Do you have asthma?.....YES / NO
29. Do you have epilepsy or seizure disorders?..... YES / NO
30. Do you or have you ever had a venereal disease?.....YES / NO
31. Have you tested positive for HIV?..... YES / NO
32. Do you have AIDS?.....YES / NO
33. Have you had or do you test positive for Hepatitis?.....YES / NO
34. Do you or have you had Tuberculosis (TB)?.....YES / NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? How much? _____ YES / NO
36. Do you regularly consume more than one or two alcoholic beverages a day?..... YES / NO
37. Have you had psychiatric treatment?.....YES / NO
38. Do you habitually use controlled substances, legal or illegal?.....YES / NO
39. Have you taken any of the following? Fenfluramine, fenfluramine combined with phentermine (fen-phen), Dexfenfluramine (redux), or other weight loss products?.....YES / NO
40. Do you have any disease condition, or problem not listed? If so, list _____
41. Is there anything else we should know about your health that we have not covered in this form? _____
42. Would you like to speak to the Doctor privately about any problem?.....YES / NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

DATE _____
PATIENT'S/ GUARDIAN'S SIGNATURE _____

DENTIST'S SIGNATURE _____ DATE _____

Patient's Name _____ /_____/_____
Last First MI Date of Birth

1. Do you have mercury/silver fillings? _____ How many? _____ Since When? _____
2. Have any of your mercury/silver fillings been replaced? _____ With what? _____ When? _____
3. Were your fillings removed with a rubber dam? _____ Clean-up device? _____ Alternate breathing source? _____
4. Did you have mercury/silver fillings in your baby teeth? _____ How many? _____
5. Did you have all of your childhood vaccines? _____ Do you currently take the flu vaccine? _____ How often? _____
Any other boosters? (List) _____ When? _____
6. Where did you grow up? _____ City / County _____
7. Were you on or near farms? _____ Herbicides / Pesticides / Insecticides _____
8. Were you near large industry? _____ Chemical Plants? _____ Processing Plants? _____
9. What are all the jobs you have held? (List) _____

10. What hobbies have you done with paints or other chemicals/ liquids? _____

11. Have you ever siphoned gasoline with your mouth or washed your hands in gasoline? _____
12. Did you ever play or work in apple, peach, citrus or other orchards? _____
13. When were you diagnosed with Mercury or Heavy Metal Toxicity? _____
14. How was the diagnosis made? _____ Are there lab reports? (please provide copy) _____
15. Have you been doing any detoxification? _____ What kinds? _____
Under whose care? _____ How long? _____ Any problems? _____
16. What was the reason that you ended up with the diagnosis of Heavy Metal Toxicity? _____
Do you have a diagnosed disease or disability thought to be related? _____ What? _____
17. Who diagnosed your disease now thought to be related to Heavy Metal Toxicity? _____
Are you still seeing that provider? _____ Are they supportive of alternative care? _____ Do they know you are here? _____
18. Who else do you see besides the provider who sent you here (if referred)? Please list. _____

19. What are your beliefs or understandings about Heavy metal toxicity? _____

20. What are your goals for being here? _____
