Maxwell Lee Gilliam, D.D.S.
General Dentistry

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HEALTH EVALUATION QUESTIONNAIRE

THE FOLLOWING INFORMATION AND HISTORY IS NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOU, THE PATIENT. THANK YOU FOR COMPLETING IN FULL.

PATIENT NAME: FIRST_____ MIDDLE_____ LAST_____ DATE_____

1. Are you presently in good health?	YES ❑	NO ❑
2. Have you ever had a serious illness?	YES ❑	NO ❑
If yes, what?_____		
3. Have you been hospitalized in the last five years?	YES ❑	NO ❑
If so, why?_____		
4. Have you been cared for by a physician during the last 6 months?	YES ❑	NO ❑
5. Are you taking any drugs or medications at the present time?	YES ❑	NO ❑
If yes, what?_____		
6. Are you bothered by constant coughing?	YES ❑	NO ❑
7. Do you get short of breath easily?	YES ❑	NO ❑
8. Do you bleed excessively after tooth extraction or other surgery?	YES ❑	NO ❑
9. Are you handicapped?	YES ❑	NO ❑
10. Females only - Are you pregnant?	YES ❑	NO ❑
11. - Are you using birth control pills?	YES ❑	NO ❑
12. Have you ever had a problem with local or general anesthesia?	YES ❑	NO ❑
13. Are you allergic to (or had a reaction to) any drug or medication?	YES ❑	NO ❑
14. Have you ever tested positive for AIDS or AIDS related symptoms?	YES ❑	NO ❑
15. Have you ever been or are you now being treated for a nervous condition?	YES ❑	NO ❑

Have you ever had the following?

1. Thyroid disease	YES ❑	NO ❑
2. Hepatitis (jaundice, yellow eyes, etc.)	YES ❑	NO ❑
3. Heart disease (angina, coronary, heart attack, etc.)	YES ❑	NO ❑
4. Cancer/Tumors	YES ❑	NO ❑
5. Chemotherapy or Radiation therapy	YES ❑	NO ❑
6. High blood pressure	YES ❑	NO ❑
7. Asthma/Hay fever	YES ❑	NO ❑
8. Acid reflux	YES ❑	NO ❑
9. Liver disease/Cirrhosis	YES ❑	NO ❑
10. Sickle cell anemia/Severe anemia	YES ❑	NO ❑
11. Epilepsy (fits or convulsions); periods of unconsciousness	YES ❑	NO ❑
12. Rheumatic fever or growing pains	YES ❑	NO ❑
13. Diabetes (sugar in the blood)	YES ❑	NO ❑
14. Tuberculosis	YES ❑	NO ❑
15. Kidney disease	YES ❑	NO ❑
16. Heart murmur	YES ❑	NO ❑
17. Drug addiction	YES ❑	NO ❑

18. Family Physician (Name)_____

Reason for dental visit?_____

When was your last visit to a dentist? Reason?_____

Date of your last dental x-rays?_____ Who may we thank for your visit?_____

I, the undersigned, certify that the above statements are true and hereby authorize the doctors and assistants to perform the necessary surgery and treatments and such additional operations or procedures as are considered therapeutically indicated on the basis of findings during the course of said operation including the administration of such anesthetics as are necessary in the judgment of the doctor. I fully understand the above operation for treatment, the reason why the treatment is considered necessary and its advantages and possible complications including swelling, bleeding, loss of tooth parts or fillings, sinus involvement, infection, jaw fracture, temporary and permanent numbness and other complications. No guarantee or assurance has been made to me as to the results that may be obtained.

Signed:_____ Date:_____

DENTAL HISTORY

	Yes	No
Do you visit the dentist regularly?	❑	❑
If not, why not? _____		
Do you brush three times a day? If not, how often?	❑	❑
Do you floss once per day?	❑	❑
Are you having oral pain or discomfort?	❑	❑
If so, is it related to the gums or to the teeth? _____		
Have you ever had an Oral Cancer screening?	❑	❑

PLEASE PRINT

PATIENT INFORMATION

Last Name: _____ First Name: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Work Phone: _____

Birthdate: _____ Race: _____ Sex: M F Social Security #: _____

METHOD OF PAYMENT PLEASE CIRCLE			
Insurance	Medicaid	Cash	Charge

PRIMARY INSURANCE INFORMATION

Dental Insurance Company: _____

Guarantor/Person Insured: _____
Last First

Address: _____
City State Zip

Social Security #: _____

Birthdate: _____

Employer: _____

Employer Address: _____
City State Zip

Employer Phone: _____

Group Plan #: _____

SECONDARY INSURANCE INFORMATION

Dental Insurance Company: _____

Guarantor/Person Insured: _____
Last First

Address: _____
City State Zip

Social Security #: _____

Birthdate: _____

Employer: _____

Employer Address: _____
City State Zip

Employer Phone: _____

Group Plan #: _____