Reid & Reid

Pediatric Dentistry • Orthodontics

WELCOME! Please complete the questionnaire and bring it with you to your appointment.
We look forward to seeing you on: **DATE**___________________**TIME** ___________________

General Information:
Please provide us with the following information:

Patient's Name: Last___________________ First _______________ MI______ Gender __________
Birth Date ___________________________Age ________________ SSN _____________________
Address _____________________________City _______________State ______ Zip ____________
Home Phone _________________________
School ______________________ Grade_______
Siblings ______________________ Ages _______
Hobbies _______________________

Responsible Party ___________________ Relationship to patient ___________________________
SSN___________________________ Date of Birth _____________________ Marital Status ____
Address _____________________________City __________________State ______ Zip ___________
Home Phone __________________Work Phone _________________ May we contact you at work? ____
Employer____________________________________Position _________________________________
Employer Address ____________________________City ____________State ______ Zip __________
Dental Insurance____________________ Phone ___________________ Group # __________________
Subscriber's name ______________________ Subscriber's birth date _________ Policy # ______________
Insurance Address ____________________________City ____________State ______ Zip __________

Whom may we thank for referring you to our office? ______________________________

Health History Questionnaire

Instructions:

1. Please answer every question by checking yes or no.
2. **Please sign and date the last page and bring this form with you to your appointment.**

Medical History for (Name): ____

Physician name __________________________Date of last visit __________________________________
What is patient's approximate height? _______ft ______in. What is patient's approximate weight? ________lbs.

	YES	NO	
Are you in good health?			
Have you had regular medical exams?			
Are you presently taking medicine?			If so, what? _________________
Are you allergic to any medications?			If so, what? _________________
Are you presently undergoing medical treatment?			If so, what? _________________
Have you been hospitalized since birth?			Date_____Reason_____________
Have you had a blood transfusion?			Date_____Reason_____________
Have you had any surgery?			Date_____Reason_____________
Do you smoke or use other tobacco products?			
Do you use any non-prescription drugs?			If so, what? _________________

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History Of Problems:	YES	NO
Head/Neck		
Eye		
Ear/ hearing		
Nose/ sinus		
Throat		
Lung		
Asthma		
Tuberculosis		
Heart (murmur)		
Rheumatic Fever		
High blood pressure		
Thyroid		
Cancer/ tumor		
Kidney		
Stomach/ Intestine		

History of Problems:	YES	NO
Skin		
Bleeding/ hemophilia		
Hepatitis/ liver		
HIV or AIDS		
Cleft lip and palate		
Epilepsy/ seizures		
Congenital birth defects		
Blood disorder		
Allergic Reactions		
Drug Reactions		
Anesthetic Reactions		
Psychological		
Attention Deficit Disorder		
Diabetes		

IF **YES** IS CHECKED FOR ANY OF THE ABOVE, **PLEASE** LIST THE SPECIFIC PROBLEM(S) AND ANY CURRENT MEDICATIONS ASSOCIATED WITH EACH PROBLEM(S); **PLEASE BE SPECIFIC:**

____
____
____
____
____

Dental History:

Name of family dentist:________________________ Date of your last visit: ____________________
How often do you brush? _______________ Floss?____________

Today's chief concern: ____

History of:	YES	NO	
Tooth injury			Chipped __ Broken__ Lost__
Jaw injury			Age __
Bleeding gums			Usually ___ Sometimes __ Rarely __ When: __Brushing __Flossing __Eating
Oral disease			Ulcers __ Sores__ Cancer __
Grinding teeth			During the day __ During the night__
Clenching teeth			During the day __ During the night__
Oral habits			Thumb sucking __ Finger sucking __ Tongue thrusting __ Nail biting __
Jaw joint pain			Right TMJ: ___Constant ___ Periodic When you: __ chew __talk __ open __ close Left TMJ: ___ Constant ___ Periodic When you: __ chew __talk __ open __ close
Jaw joint noises			Right: ___ clicking ___ popping ___ grating ___ Left: ___ clicking ___ popping ___ grating ___
Jaw joint locking			Right: ___when open ____when closed ____ Left: ___ when open ____when closed ____

Have you had:	YES	NO	Explain Treatment	Date	Doctor:
Periodontal treatment?			____________________	________	_______________
Orthodontic treatment?			____________________	________	_______________
Root canal treatment?			____________________	________	_______________
Oral Surgery?			____________________	________	_______________
Dental treatment?			____________________	________	_______________

Women Only:
Are you pregnant now or do you think you may be? ____ Do you anticipate becoming pregnant? ___

I hereby certify that I have reviewed the above medical and dental history and agree it is, to the best of my knowledge, accurate at this time. If there are any future changes in this information I will inform the practice of these changes. I agree to diagnostic procedures found necessary and desirable by Alison C. Reid, DDS, MS to determine my orthodontic needs.

Signature of person filling out this health history form ______________________________Date______________________________

Signature of doctor who reviewed this form ______________________________________ Date______________________________