Reid & Reid
Pediatric Dentistry • Orthodontics

WELCOME to Reid & Reid Pediatric Dentistry and Orthodontics! 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 _____

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	
Is your child in good health?	☐	☐	
Does your child have regular medical exams?	☐	☐	
Is your child up to date with immunizations?	☐	☐	
Is your child presently taking medicine?	☐	☐	If so, what? _____
Is your child allergic to any medications?	☐	☐	If so, what? _____
Is your child presently undergoing medical treatment?	☐	☐	If so, what? _____
Has your child been hospitalized since birth?	☐	☐	Date_____Reason_____
Has your child had a blood transfusion?	☐	☐	Date_____Reason_____
Has your child had any surgery?	☐	☐	Date_____Reason_____

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(828) 696-2245

History Of Problems:	YES	NO	History of Problems:	YES	NO
Head/Neck	☐	☐	Skin	☐	☐
Eye	☐	☐	Bleeding/ hemophilia	☐	☐
Ear/ hearing	☐	☐	Hepatitis/ liver	☐	☐
Nose/ sinus	☐	☐	HIV or AIDS	☐	☐
Throat	☐	☐	Cleft lip and palate	☐	☐
Lung	☐	☐	Epilepsy/ seizures	☐	☐
Asthma	☐	☐	Congenital birth defects	☐	☐
Tuberculosis	☐	☐	Autism	☐	☐
Cerebral Palsy	☐	☐	Developmental delay	☐	☐
Heart (murmur)	☐	☐	Allergic Reactions	☐	☐
Rheumatic Fever	☐	☐	Drug Reactions	☐	☐
Thyroid	☐	☐	Anesthetic Reactions	☐	☐
Cancer/ tumor	☐	☐	Psychological	☐	☐
Kidney	☐	☐	Attention Deficit Disorder	☐	☐
Stomach/ Intestine	☐	☐	Diabetes	☐	☐

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

_____
_____
_____
_____
_____

Dental History

Name of family dentist:_____ Date of patient's last visit: _____
How often does the patient brush? _____ Floss?_____
What is your water source?_____
Has your child had an unfavorable experience in the dental office?_____
Have you had an unfavorable experience in a dental office?_____
Does your child have a toothache?_____
Purpose of this visit_____
Is your child a finger-sucker, thumb-sucker or pacifier user?_____

Is there any other information you think might be of value to us in treating your child?_____
_____

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 and dental treatment as found necessary and desirable by Richard B. Reid, DDS for the patient named above. As a new patient, I am responsible for my account the day of service.

Signature of person filling out this health history form _____Date_____

Signature of doctor who reviewed this form _____ Date_____

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