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

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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 ANY 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?_____

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 ____

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Has the patient had:	YES	NO	Explain Treatment	Date	Doctor:
Periodontal treatment?	☐	☐	_____	_____	_____
Orthodontic treatment?	☐	☐	_____	_____	_____
Root canal treatment?	☐	☐	_____	_____	_____
Oral Surgery?	☐	☐	_____	_____	_____
Dental treatment?	☐	☐	_____	_____	_____

Onset of puberty

Females onset of menstruation (approx. date) _____?

Males onset of voice change (approx. data) _____?

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 child's orthodontic needs.

Signature of person filling out this health history form _____Date_____

Signature of doctor who reviewed this form _____ Date_____

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