Please print, complete, and bring form to your consultation appointment.

Electronic Forms Coming Soon

TWADDLE ORTHODONTICS
BRAD A. TWADDLE DDS, MSD

Red asterisks designate required fields.

Adult Health History Form

About You	
* Date	
* Patient Name	
Nickname	
* Sex	◯ Female ◯ Male
* Birth Date	Age:
* Address	
* Phone #	
* Email (appt. reminders)	
* Employer	
* Job Position	
* How Long in This Position?	
* General Dentist	
* Whom may we thank for referring you?	

Spouse Information	
Marital Status	
Partner's Name	
Phone #	

Responsible Party	
* Who is responsible for this account?_____	
Billing Address (if different from above)	
Phone #	
Employer	
Job Position	

Primary Insurance Information	
* Do you have orthodontic coverage? ◯ Yes ◯ No	
Insurance Co.	
Insurance Address	
Phone #	
Insured's Name	
Insured's Date of Birth	
Insured's SSN (or Member ID)	
Phone #	
Group #	

Secondary Insurance Information (if applicable)	
Insurance Co.	
Insurance Address	
Phone #	
Insured's Name	
Insured's Date of Birth	
Insured's SSN (or Member ID)	
Phone #	
Group #	

Emergency Contact	
Emergency Contact Name	
Relation	
Phone #	

Are there any important details about your personal information or billing concerns which you'd like us to know about? ◯ Yes ◯ No
If yes, use this space to elaborate:

Dental & Medical History

Dental History	circle one
Has you ever been evaluated or had orthodontic treatment before?	Y N
Have there been any injuries to your face, mouth, teeth or chin?	Y N
Do you require antibiotics before dental treatment?	Y N
Have adenoids or tonsils been removed?	Y N
Do you have any missing or extra permanent teeth?	Y N
Have you ever had any pain/tenderness in your jaw joints (TMJ/TMD)?	Y N
Do you brush your teeth daily?	Y N
Floss your teeth daily?	Y N
Do you clench or grind teeth?	Y N
Nail biter?	Y N
Mouth breather?	Y N
Tongue thrust?	Y N
Speech problems?	Y N
Do you smoke or use tobacco products?	Y N
(For women) Are you currently pregnant?	Y N
If yes, how many weeks?	
Are you nursing?	Y N

List all medications you are currently taking:

Aside from the list below, list all drugs/things you are allergic to:

* **Latex** Y N * **Nickel/Metals** Y N * **Plastic** Y N

What are the main concerns that you would like orthodontics to accomplish?

Have you experienced any of the following medical problems?	circle one		circle one
Abnormal Bleeding	Y N	Hearing Impairment	Y N
ADD/ADHD	Y N	Heart Murmur	Y N
AIDS/HIV+	Y N	Hemophilia	Y N
Hospital Stays/Operations	Y N	Hepatitis	Y N
Artificial Bones/Joints	Y N	Kidney Problems	Y N
Asthma	Y N	Liver Problems	Y N
Cancer	Y N	Mitral Valve Prolapse	Y N
Congenital Heart Defect	Y N	Prosthetics	Y N
Convulsions	Y N	Rheumatic Fever	Y N
Diabetes	Y N	Scarlet Fever	Y N
Epilepsy	Y N	Sickle Cell Disease/Traits	Y N
Handicaps/Disabilities	Y N	Tuberculosis	Y N

Have you ever taken diet pills such as Phen-Fen (also known as Redux or Pondimin)?	Y N
Are your immunizations current?	Y N
Anything you would like to discuss with the doctor in private?	Y N
Are you currently under the care of a physician?	Y N

Primary Physician:

Last Visit Date:

Describe your physical health: ◯ Good ◯ Fair ◯ Poor

Please discuss any serious medical problems you have had:

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize this dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.
I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental/orthodontic services I may need.

* Signature: * Date: