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.

Child Health History Form

Tell Us About Your Child	
* Date	
* Patient Name	
Nickname	
* Sex	◯ Female ◯ Male
* Birth Date	Age:
* School	
Hobbies/Sports	
Musical Instruments	
* Child's Address	
* Phone #	
* Email (appt. reminders)	

General Information	
* Who is accompanying the child today?	
* Relationship	
* Do you have legal custody of this child? ◯ Yes ◯ No	
* Whom many we thank for referring you?	
Siblings	
* General Dentist	
Last Visit Date	
Emergency Contact	
Phone #	

Parent Information

* Who is responsible for this account? _____

* Parent's Marital Status: ◯ Single ◯ Married ◯ Partnered ◯ Divorced ◯ Separated ◯ Widowed

◯ Father ◯ Step Father ◯ Guardian	
* Name	
Birth Date	
Address (if different from child)	
Phone #	
Email	
Employer	
Position	
Insurance Information (if applicable)	
Insurance Co.	
Insurance Address	
Phone #	
Insured's SSN	

◯ Mother ◯ Step Mother ◯ Guardian	
* Name	
Birth Date	
Address (if different from child)	
Phone #	
Email	
Employer	
Position	
Insurance Information (if applicable)	
Insurance Co.	
Insurance Address	
Phone #	
Insured's SSN	

Dental & Medical History

Dental History	circle one
Has your child ever been evaluated or had orthodontic treatment before?	Y N
Have there been any injuries to the face, mouth, teeth or chin?	Y N
Does the child require antibiotics before dental treatment?	Y N
Have adenoids or tonsils been removed?	Y N
Does your child have any missing or extra permanent teeth?	Y N
Has the child ever had any pain/tenderness in his/her jaw joints (TMJ/TMD)?	Y N
Does the child brush his/her teeth daily?	Y N
Floss his/her teeth daily?	Y N
Was the child breast fed?	Y N
Used pacifier?	Y N
Does the child clench or grind teeth?	Y N
Nail biter?	Y N
Mouth breather?	Y N
Thumb/Finger sucking?	Y N
Tongue thrust?	Y N
Speech problems?	Y N

List all medications the child is currently taking:

Aside from the list below, list all drugs/things your child is allergic to:

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

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

Has your child 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

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

Child's Physician:

Last Visit Date:

Describe the child's physical health: ◯ Good ◯ Fair ◯ Poor

Please discuss any serious medical problems the child has 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 child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

* Signature of Parent/Guardian: * Date: