

Camille VanDevanter, D.D.S., M.S.D., P.S.

Specialist in Orthodontics

WELCOME TO OUR OFFICE! We appreciate the opportunity to provide you with a preliminary evaluation. We hope that the following information will answer some of your immediate questions.

NO ONE IS EVER TOO OLD to begin orthodontic treatment! In general, tooth position can be improved at any age, even though there is a tendency to associate orthodontics with children. Age is not a factor if the tissue of your gums and the bone supporting your teeth are healthy and normal.

SOME OF THE PROBLEMS that can be helped with orthodontics include:

- Spacing or crowding of the front teeth
- Protruding teeth
- Teeth tilted into spaces created by tooth loss
- Straightening of teeth that for any reason have assumed abnormal positions in the mouth

ORTHODONTIC TREATMENT ACHIEVES:

- A sound occlusion (bite) within a healthy dental environment
- A more attractive smile and often an improvement in facial contours and appearance
- Protection from damage to healthy teeth caused by a malocclusion (bad bite/crooked teeth)

DURING YOUR FIRST APPOINTMENT, Dr. VanDevanter will advise you of the following:

- Whether there is an orthodontic problem present
- When and how the problem should be addressed
- How long correction would take

Please be assured that this examination does not involve any discomfort!

A PRECISE PROGRAM, designed around your individual needs, will require a more thorough evaluation involving the following appointments:

- **ORTHODONTIC RECORDS**— Are necessary for a complete evaluation and treatment plan. Orthodontic records commonly include: a panoramic radiograph, cephalometric radiograph, facial and intraoral photographs, periodontal charting, dental history, and study models of the teeth. If Orthodontic Records are recommended by Dr. VanDevanter, they may be completed during the first visit with our office. Dr. VanDevanter has an advanced dental digital imaging system and a staff trained with current techniques in orthodontic imaging. This equipment offers the highest reliability and provides clinically excellent maxillofacial diagnostic imaging.
- **TREATMENT CONSULTATION**— It will take some time for Dr. VanDevanter to assess your records and correspond with your general dentist. You will be presented with diagnostic findings and treatment options during a consultation appointment. Your financial investment in orthodontic treatment will also be presented at this time. Most arrangements require a down payment and monthly payments over the course of treatment.

33507 9th Ave. S. Building # G • Federal Way, Washington 98003
(253) 661-7228 or 927-8391

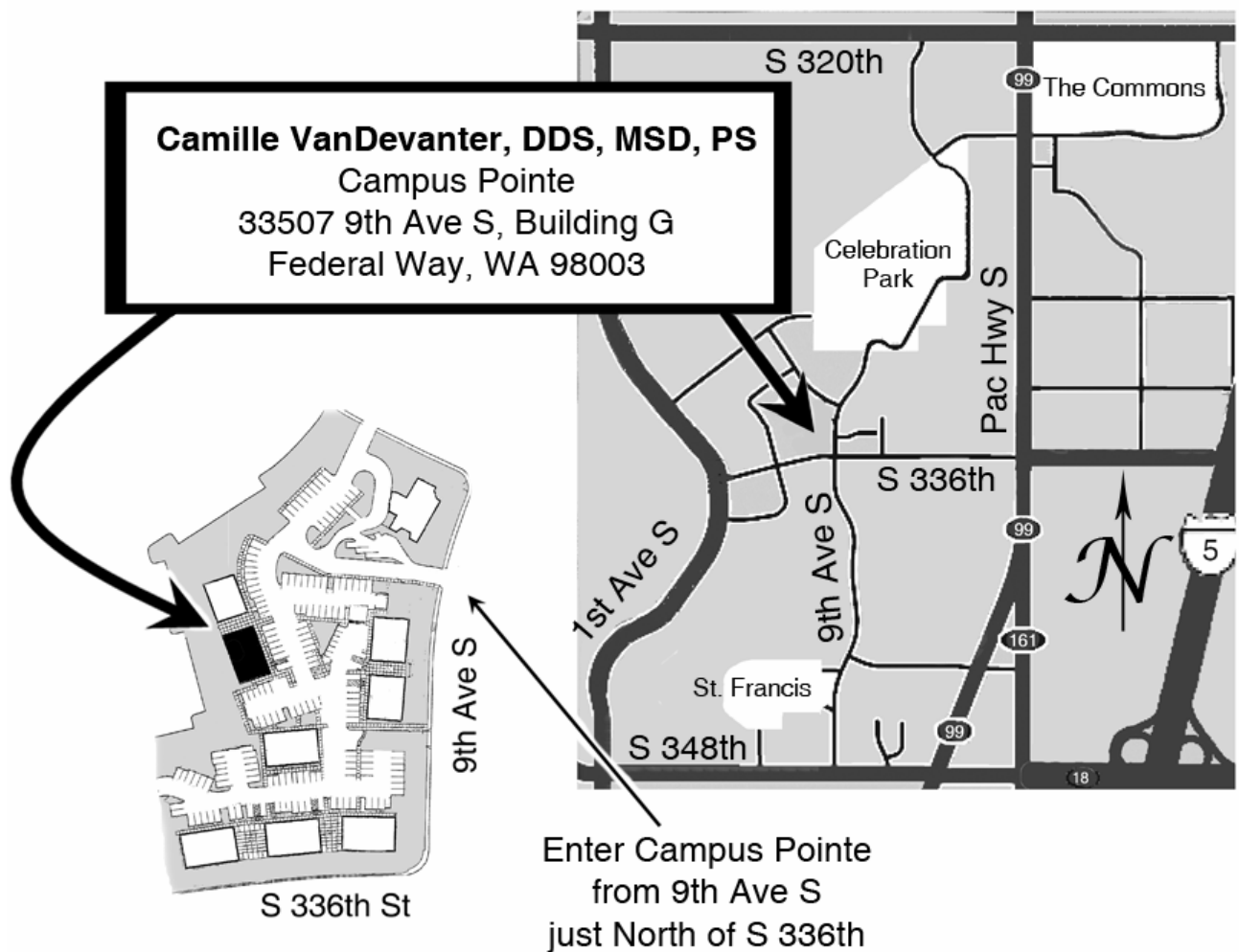
www.drvandevanter.com

WHAT DO THESE FIRST APPOINTMENTS COST?

- The preliminary evaluation is performed as a courtesy to our new patients.
- For a complete orthodontic treatment plan radiographs (x-rays), pictures, and study models will be needed. The general cost for these orthodontic records are \$400.00.

We are always available to help you with questions or problems. Our philosophy is to provide the finest orthodontic care while making the treatment experience an enjoyable and positive team effort. We are proud to provide a service that is of lasting benefit.

We look forward to meeting you!



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WELCOME TO OUR PRACTICE

So that we might become better acquainted, please complete **BOTH** sides of this form and bring it with you to your appointment.

ADULT PATIENT INFORMATION

Patient's Name: _____	Preferred Name: _____	Sex: M ___ F ___	
Home Address: _____	City: _____	Zip: _____	
How long at this address: Years: _____	Home Telephone: _____	Cell Number: _____	
Date of Birth: _____	Age: _____	E-mail: _____	Do you smoke? Yes ___ No ___
Patient's General Dentist: _____	Phone: _____		
Please describe your orthodontic problem: _____			
What concerns you most about the thought of orthodontic treatment? _____			
Whom may we thank for referring you to our office? _____			
Other family members currently in our practice: _____			
Acquaintances currently in our practice: _____			

FAMILY INFORMATION

Spouse's Name: _____	Cell Number: _____
Person responsible for account: _____	Relationship to Patient: _____
Home address if different than patient: _____	City: _____
How long at this address: Years: _____	Home phone if different than patient: _____

EMPLOYMENT INFORMATION Name: _____	Name: _____
Employer: _____	Employer: _____
Employer's Address: _____	Employer's Address: _____
Employer's Phone Number: _____	Employer's Phone Number: _____

INSURANCE INFORMATION

Subscriber's Name: _____	Subscriber's Name: _____
Date of Birth: _____	Date of Birth: _____
Social Security: _____	Social Security: _____
Dental Insurance Co.: _____	Dental Insurance Co.: _____
Insurance Phone: _____	Insurance Phone: _____
Group Number: _____	Group Number: _____

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Please see reverse

For office use only: Date: _____

Received by: _____

Your answers to the following questions will be helpful in determining an appropriate plan of treatment. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name: _____ Address: _____ Telephone: (____) _____

- | | Yes | No | |
|---|--------------------------|--------------------------|----------------|
| Have you experienced any health problems? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Any major change in your health recently? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Are you currently under a physician's care? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Are you allergic to any medications? | <input type="checkbox"/> | <input type="checkbox"/> | List: _____ |
| Are you currently taking medications? | <input type="checkbox"/> | <input type="checkbox"/> | List: _____ |
| Have you received a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> | Reason: _____ |
| Have your tonsils or adenoids been removed? | <input type="checkbox"/> | <input type="checkbox"/> | When: _____ |
| Have you had any facial surgeries? | <input type="checkbox"/> | <input type="checkbox"/> | When: _____ |
| Have you had any surgery in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | When: _____ |
| Any medical condition that requires a special diet? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Are you in a risk group for AIDS? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |

Please check if you have had any of the following conditions:

- | | | | | | | | |
|--------------------------|--------------------------|------------------------------|--------------------------|------------------------------|--------------------------|-------------------------|--------------------------|
| Anemia..... | <input type="checkbox"/> | Emotional Problems, etc..... | <input type="checkbox"/> | Hepatitis..... | <input type="checkbox"/> | Prolonged Bleeding..... | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | Endocrine Disorders..... | <input type="checkbox"/> | Herpes (Fever Blisters)..... | <input type="checkbox"/> | Rheumatic Fever..... | <input type="checkbox"/> |
| Blood Disease..... | <input type="checkbox"/> | Epilepsy..... | <input type="checkbox"/> | Hives/Rash | <input type="checkbox"/> | Sleep Apnea..... | <input type="checkbox"/> |
| Bronchitis..... | <input type="checkbox"/> | Fainting..... | <input type="checkbox"/> | Kidney Disease..... | <input type="checkbox"/> | Thyroid Disorder..... | <input type="checkbox"/> |
| Bone Disorders..... | <input type="checkbox"/> | Frequent Headaches..... | <input type="checkbox"/> | Liver Disease..... | <input type="checkbox"/> | Tonsillitis..... | <input type="checkbox"/> |
| Cancer..... | <input type="checkbox"/> | Growth Disorders..... | <input type="checkbox"/> | Metal Allergies..... | <input type="checkbox"/> | Tuberculosis..... | <input type="checkbox"/> |
| Developmental Disorder.. | <input type="checkbox"/> | Heart Murmur..... | <input type="checkbox"/> | Mouth Breather..... | <input type="checkbox"/> | | |
| Diabetes..... | <input type="checkbox"/> | Heart Surgery..... | <input type="checkbox"/> | Nervous/Anxious..... | <input type="checkbox"/> | | |

Is there any other condition or problem we should know about? _____
 Comments: _____

DENTAL HISTORY

Frequency of dental check-ups: Twice a year Once a year Only if a problem exists Never
 **Date of last visit to dentist: _____

- | | Yes | No | |
|---|--------------------------|--------------------------|------------------|
| Is there any unfinished care to be completed with your dentist? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Have you had an unpleasant experience in a dental office? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Have you had any facial or dental injuries? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Have you consulted with an orthodontist previously? | <input type="checkbox"/> | <input type="checkbox"/> | With Whom? _____ |
| Have any permanent teeth been removed other than wisdom teeth? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you had any previous orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> | With Whom? _____ |
| Are you satisfied with prior treatment? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Have you noticed changes in your bite or dental alignment recently? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Has a physician recommended medication for bone density? | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |

What are the chief concerns you have related to the position of your teeth or bite?

- Aesthetic Cleaning Comfort Ability to chew Stability

Please elaborate: _____

What concerns has your dentist(s) expressed concerning your bite or dental alignment?

- Wear or fractures of teeth Difficulty with cleaning related to alignment of teeth
 Bone or gum tissue loss Jaw joint or muscle tightness or discomfort
 Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)
 Other: _____

Please check if there is a history of:

- Clenching teeth Muscular soreness around head and neck Jaw joint soreness Jaw joint popping
 Grinding teeth Headaches (more than normal) Jaw joint clicking Ringing in the ears
 Speech problems: Yes _____ No _____ If yes, which sounds? _____
 Mouth breathing: Awake _____ Asleep _____ Tongue Thrusting: Yes _____ No _____ Snoring: Yes _____ No _____
 Is there any other information that may be helpful? _____

Patient's Signature: _____ Date: _____ Reviewed By: _____

**** A recent cleaning and check-up (within the last 6 months) will be necessary before orthodontic appliances can be placed.**

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