

**WELCOME TO OUR OFFICE!** We appreciate the opportunity to provide your child with an orthodontic evaluation. We hope that the following information will answer some of your immediate questions.

**WHAT HAPPENS DURING THE EXAMINATION?** During this first visit, Dr. VanDevanter will examine your child's mouth and make an evaluation of the size of the dental arches, the bite, the space for eruption, the number and position of developing permanent teeth. Please reassure your child that the examination does not involve any discomfort.

Not all children should be treated at the same age or stage of development, because no two malocclusions (bite problems) are alike. Certain malocclusions lend themselves best to treatment when some baby teeth are still present and the jaws are developing. Others should be started later, after all of the adult teeth have erupted. At this visit Dr. VanDevanter will advise you of the following:

- ◆ The possibility of orthodontic problems developing.
- ◆ Any orthodontic problems that should be addressed immediately and how long correction will take.
- ◆ Any orthodontic problems that should be watched and addressed at a later date.

**WHAT NEXT?** On the basis of a preliminary evaluation, only a general diagnosis can be made. Depending on the condition of your child's bite, Dr. VanDevanter will suggest one of the following:

- ◆ **WAIT**-Treatment at this time would not lessen or prevent a problem. We may suggest that your child return on a periodic recall so that we can monitor the dental development and make appropriate and timely recommendations.
- ◆ **PROCEED WITH A COMPLETE EVALUATION**- If treatment is recommended now, a thorough evaluation will be needed. A detailed written assessment and treatment options will be prepared. To establish a treatment plan the following appointments are necessary:

**ORTHODONTIC RECORDS**— Are necessary for a complete orthodontic evaluation. Orthodontic records include a panoramic radiograph, cephalometric radiograph, facial and intraorally photographs, 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 on current techniques in orthodontic imaging. This equipment offers the highest reliability and provides clinically excellent maxillofacial diagnostic imaging.

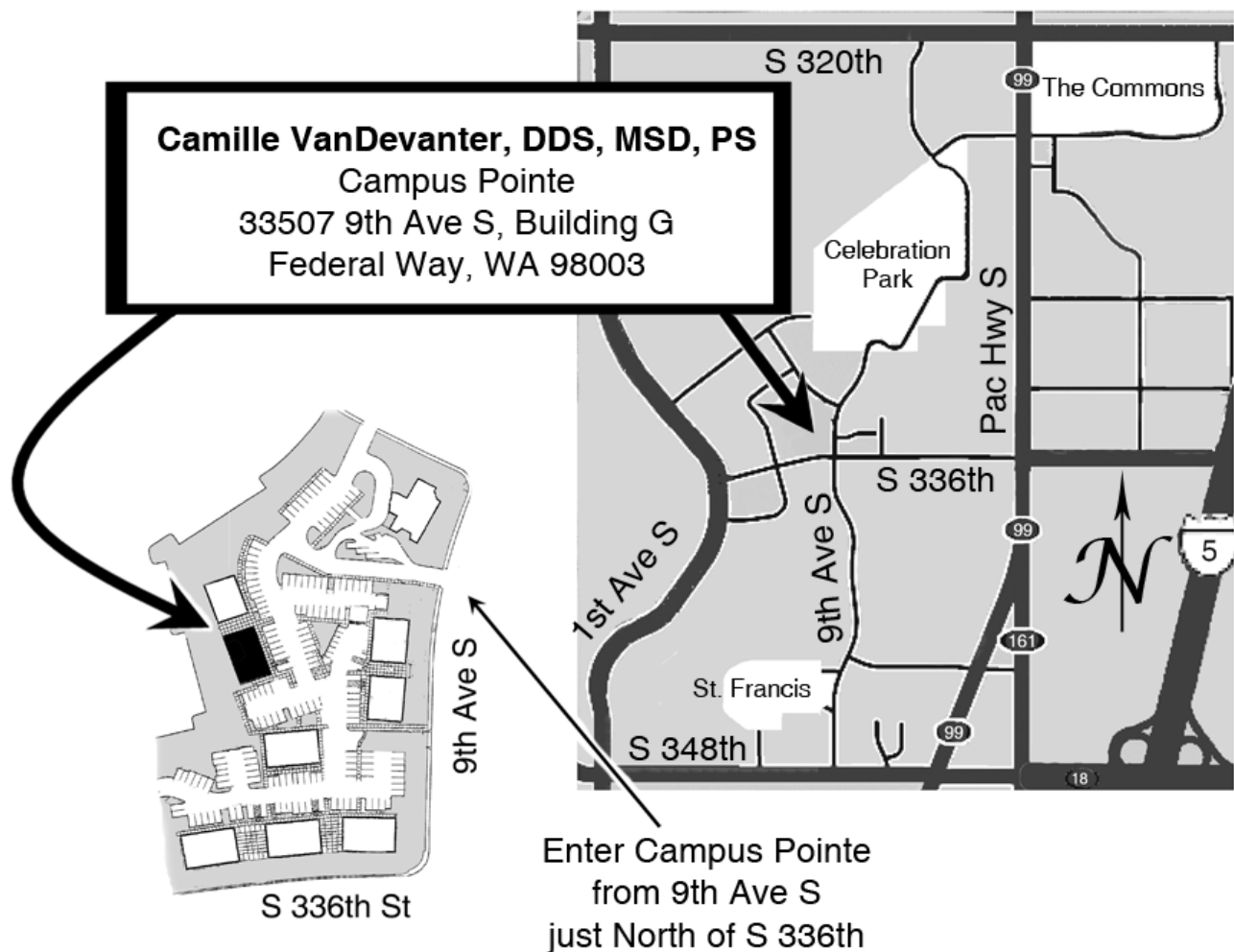
**TREATMENT CONSULTATION**— It will take some time for Dr. VanDevanter to assess your records and correspond with your general dentist. You will be presented with all diagnostic findings and treatment options during a consultation appointment. Your financial investment in orthodontic treatment will also be presented at this time. Most arrangements require a down payment with the balance payable over the course of treatment.

## 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!**



**Camille VanDevanter D.D.S., M.S.D. Specialist in Orthodontics  
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.

**PATIENT INFORMATION FOR MINORS**

Patient's Name: _____		Preferred Name: _____		Sex: M ___ F ___	
Date of Birth: _____		Age: _____		Adopted: Yes ___ No ___	
Home Address: _____		City: _____		Zip: _____	
Home Telephone: _____		Cell Number: _____			
Patient's General Dentist: _____			Phone: _____		
School: _____			Grade: _____		
History of thumb or finger sucking: Yes ___ No ___ If yes, Stopped? Yes ___ No ___ Nail Biting: Yes ___ No ___					
Other family members currently in our practice: _____					
Names and birthdates of siblings: _____					
Have either siblings or parents had orthodontic treatment? Yes ___ No ___					
If yes, who was your orthodontist? _____					
Whom may we thank for referring you to our office? _____					
Patient's Sports/Hobbies: _____					

**FAMILY INFORMATION**

Child lives with: _____		E-mail Address: _____	
Father: _____		Date of Birth: _____	
		Cell Phone: _____	
Mother: _____		Date of Birth: _____	
		Cell Phone: _____	
Single: ___ Married: ___ Divorced: ___ Widowed: ___			
Address, if different than patient: _____		Father: _____	
		Mother: _____	
Home telephone, if different than patient: _____		Father: _____	
		Mother: _____	
Financially responsible person: _____			
Relationship to 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: _____	
Relationship to Patient: _____		Relationship to Patient: _____	
Date of Birth: _____		Date of Birth: _____	
Social Security: _____		Social Security: _____	
Dental Insurance Co.: _____		Dental Insurance Co.: _____	
Group Number: _____		Group Number: _____	
Insurance Phone: _____		Insurance Phone: _____	

33507 Ninth Ave. Campus Pointe – Bldg G Federal Way, WA 98003 (253) 661-7228 or (253) 927-8391  
*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                       |                |
|--|--------------------------|--------------------------|----------------|
| Has your child experienced any health problems? .....    | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Any major change in your child's health recently? .....  | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Is your child currently under a physician's care? .....  | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |
| Is your child allergic to any medications?.....          | <input type="checkbox"/> | <input type="checkbox"/> | List: _____    |
| Is your child currently taking medications?.....         | <input type="checkbox"/> | <input type="checkbox"/> | List: _____    |
| Has your child received a blood transfusion?.....        | <input type="checkbox"/> | <input type="checkbox"/> | Reason: _____  |
| Have your child's tonsils or adenoids been removed?..... | <input type="checkbox"/> | <input type="checkbox"/> | When: _____    |
| Has your child been in a risk group for AIDS?.....       | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____ |

**Please check if your child has 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: \_\_\_\_\_

**GROWTH INFORMATION FOR PATIENTS UNDER 16 YEARS OF AGE**

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

- |   | Yes                      | No                       |             |
|---|--------------------------|--------------------------|-------------|
| Has your son or daughter reached puberty?.....      | <input type="checkbox"/> | <input type="checkbox"/> |             |
| Girls...Has she started menstruation?.....          | <input type="checkbox"/> | <input type="checkbox"/> | When? _____ |
| Boys...Has his voice changed?.....                  | <input type="checkbox"/> | <input type="checkbox"/> | When? _____ |
| Height: _____ Do you feel growth is completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |             |
| Father's Height: _____ Mother's Height: _____       |                          |                          |             |

**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 child's dentist?... | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____         |
| Is your child frightened about dental treatment?.....                      | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____         |
| Has your child had an unpleasant experience in a dental office?.....       | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____         |
| Has your child had any facial or dental injuries?.....                     | <input type="checkbox"/> | <input type="checkbox"/> | Explain: _____         |
| Does your child play any musical instruments?.....                         | <input type="checkbox"/> | <input type="checkbox"/> | What instrument? _____ |
| Has your child consulted with an orthodontist previously?.....             | <input type="checkbox"/> | <input type="checkbox"/> | With Whom? _____       |
| Have any teeth (either primary or permanent) been removed?.....            | <input type="checkbox"/> | <input type="checkbox"/> |                        |
| Has your child 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: _____         |

**Please check if there is a history of:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Clenching teeth                        | <input type="checkbox"/> Muscular soreness around head and neck | <input type="checkbox"/> Jaw joint soreness  | <input type="checkbox"/> Jaw joint popping   |
| <input type="checkbox"/> Grinding teeth                         | <input type="checkbox"/> Headaches (more than normal)           | <input type="checkbox"/> Jaw joint clicking  | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Speech problems:    Yes _____ No _____ |   | Mouth breathing:    Awake _____ Asleep _____ |  |
| If yes, which sounds? _____                                     |   | Tongue Thrusting:    Yes _____ No _____      |  |

Is there any other information that may be helpful? \_\_\_\_\_

Parent'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.** Revised 2-10-2009