

**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: _____
Occupation: _____	Occupation: _____
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 |

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: \_\_\_\_\_