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.

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: _____ How many years with Dentist_____
Phone:_____

Please describe your orthodontic problem: _____

What concerns you most about the thought of orthodontic treatment? _____

Other family members currently in our practice: _____

Whom may we thank for referring you to our office? _____

Acquaintances currently in our practice: _____

FAMILY INFORMATION

Spouse's Name: _____ D.O.B.: _____ 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: _____
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: _____
Date of Birth: _____	Date of Birth: _____
Social Security: _____	Social Security: _____
Dental Insurance Co.: _____	Dental Insurance Co.: _____
Insurance Phone: _____	Insurance Phone: _____
Group Number: _____	Group Number: _____

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	
Have you experienced any health problems?	❒	❒	Explain:
Any major change in your health recently?	❒	❒	Explain:
Are you currently under a physician's care?	❒	❒	Explain:
Have you received a blood transfusion?	❒	❒	Explain:
Are you in a risk group for AIDS?	❒	❒	Explain:
Have your tonsils or adenoids been removed?	❒	❒	When:
Have you had any facial surgeries?	❒	❒	When:
Have you had any surgery in the last 12 months?	❒	❒	When:
Any medical condition that requires a special diet?	❒	❒	Explain:
Are you allergic to any medications?	❒	❒	List:
Has a physician recommended medication for bone density?	❒	❒	Explain:

Current medications?	Name:	Dosage:	Purpose:
	Name:	Dosage:	Purpose:

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

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

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 with dentist: _____ Date of last dental *cleaning* with dentist: _____

	Yes	No	
Is there any unfinished care to be completed with your dentist?.....	❒	❒	Explain: _____
Have you had an unpleasant experience in a dental office?.....	❒	❒	Explain: _____
Have you had any facial or dental injuries?……	❒	❒	Explain: _____
Have you consulted with an orthodontist previously?……	❒	❒	With Whom? _____
Have any permanent teeth been removed other than wisdom teeth?……	❒	❒	
Have you had any previous orthodontic treatment?……..	❒	❒	With Whom? _____
Are you satisfied with prior treatment?……	❒	❒	Explain: _____
Have you noticed changes in your bite or dental alignment recently?……	❒	❒	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
❒ Bone or gum tissue loss
❒ Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)
❒ Other_____
❒ Difficulty with cleaning related to alignment of teeth
❒ Jaw joint or muscle tightness or discomfort

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.** Revised 1/27/15