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: _____How many years with current 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: _____How long with insurance:_____	Date of Birth: _____How long with insurance:_____
Social Security/ID #: _____	Social Security/ID #: _____
Dental Insurance Co.: _____	Dental Insurance Co.: _____
Group Number: _____	Group Number: _____
Insurance Phone: _____	Insurance Phone: _____

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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	
Does your child have behavioral problems which may impede orthodontic treatment?	❒	❒	Explain:
Has your child been diagnosed with any attention deficit disorder?	❒	❒	Explain:
Are there any oral fixations?	❒	❒	Explain:
Has your child experienced any health problems?	❒	❒	Explain:
Any major change in your child's health recently?	❒	❒	Explain:
Is your child currently under a physician's care?	❒	❒	Explain:
Is your child allergic to any medications?	❒	❒	List:
Have your child's tonsils or adenoids been removed?	❒	❒	When:

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

Please check if your child has had any of the following conditions:

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

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

GROWTH INFORMATION FOR PATIENTS UNDER 18 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	
Girls…Has she reached puberty or started menstruation?.....	❒	❒	Age at onset: _____
Boys…Has he reached puberty or his voice changed?.....	❒	❒	Age at onset: _____
Patient's Height: _____ Do you feel growth is completed?.....	❒	❒	

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

	Yes	No	
Is there any unfinished care to be completed with your child's dentist?...	❒	❒	Explain:_____
Is your child frightened about dental treatment?.....	❒	❒	Explain:_____
Has your child had an unpleasant experience in a dental office?.....	❒	❒	Explain:_____
Has your child had any facial or dental injuries?.....	❒	❒	Explain:_____
Does your child play any musical instruments?.....	❒	❒	What instrument? _____
Has your child consulted with an orthodontist previously?.....	❒	❒	With Whom? _____
Have any teeth (either primary or permanent) been removed?.....	❒	❒	
Has your child had any previous orthodontic treatment?.....	❒	❒	With Whom? _____
Are you satisfied with prior treatment?.....	❒	❒	Explain: _____

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 _____ Lisping: 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 1/27/15