Dietmeier Orthodontics

Gregory W. Dietmeier, DDS, MS, PC

Today's Date:_____/_____/_____

Salutation: Mr. Mrs. Ms. Miss Dr.

Name:_____
Last First MI

I prefer to be called:_____

Birth date: _____/_____/_____ Age:_____

Home Address:_____

_____
City State Zip

Best Contact Number: (_____)_____
Home or Cell

Additional Phone Number: (_____)_____
Home or Cell

Email_____

Preferred method of contact: _____

Marital Status:
Single Married Divorced Widowed

Employer: _____

Spouse's Name(s):_____

Emergency Contact(If different than above):

_____

Phone Number:_____

General Dentist: _____

Who may we thank for referring you?

_____

Dental Insurance: (Please complete thoroughly)

Primary Insurance:_____

Name of Policy Holder: _____

ID/Policy #:_____ SSN: _____

Group #: _____

Claims Address: _____

_____

Claims Phone #:_____

Date of Birth: _____

Employer:_____

Your Medical History

Physician's Name: _____

Phone #: (_____)_____

Date of last visit:_____/_____/_____

Are you currently under routine care of a physician?
❑Yes ❑No

If yes, please explain:_____

Are you taking any prescription/over-the-counter drugs?
❑Yes ❑No
If yes, please list:_____

Are you allergic to any of the following items?

Y N Penicillin	**Y N** Tetracycline	**Y N** Latex
Y N Aspirin	**Y N** Dental Anesthetics	**Y N** Any Metal/Plastic
Y N Erythromycin	**Y N** Codeine	**Y N** Other

Please list any drugs you are allergic to:

_____

What are your main concerns you would like orthodontics to accomplish?

_____

_____

Have you ever had or been evaluated for orthodontic treatment?

❑Yes ❑No When? _____

Your current dental health is:

Good Fair Poor

Have you ever had a serious problem associated with previous dental work? ❑Yes ❑No

When? _____

Do you have any missing or extra permanent teeth?

❑Yes ❑ No

Have you ever had an injury to your mouth, teeth or chin?

❑Yes ❑ No

Do you generally breathe through your mouth?

❑Yes ❑No

Awake, Asleep or both?_____

Have you ever had any of the following diseases or medical problems?

Y N Heart attack/stroke
Y N Heart Murmur
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N HIV+/AIDS
Y N Hemophilia
Y N Asthma/Arthritis
Y N Hepatitis
Y N Tuberculosis
Y N Artificial Joints
Y N Artificial Valves
Y N High/Low Blood Pressure
Y N Fever Blisters
Y N Drug/Alcohol Abuse
Y N Heart Surgery/Pacemaker
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Abnormal Bleeding
Y N Hearing Impairment
Y N Any Operations?
Y N Any stays in a hospital?
Y N Kidney/Liver Problems
Y N Handicaps/Disabilities
Y N Shingles
Y N Mitral Valve Prolapse
Y N Sinus Problems
Y N Psychiatric Problems
Y N Ulcers/Colitis

Please discuss any medical condition(s) that you have had:

_____

_____

Have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑Yes ❑No

Explain:_____

_____

Do your gums ever bleed?

❑Yes ❑No

- **I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.**
- **I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any fees regardless of what insurance may cover.**
- **I understand that where appropriate, credit bureau reports may be obtained.**

Signature_____Date_____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CENTER FOR DISEASE CONTROL AND THE AMERICAN DENTAL ASSOCIATION