Dietmeier Orthodontics
Gregory W. Dietmeier, DDS, MS, PC

Please Tell Us About Your Child

Today's Date:_____/______/______

Name:_______________________________________
Last First MI

Nickname:____________________ ❑Male ❑Female

Child's birth date: ______/______/______ Age:_______

Home Address:________________________________

____
City State Zip

General Dentist:_______________________________

Last visit date:________________________________

Siblings and Date(s) of Birth:

____

____

Whom may we thank for referring you?

____

Parent/Guardian Information

Parent's Marital Status:
Single Married Divorced Widowed

Name(s):_____________________________________

Relationship:__________________________________

Billing Address:________________________________

____

Best Contact Number: (______)__________________
Home or Cell

Additional Phone Number: (______)______________
Home or Cell

Email: _______________________________________

Employer: ____________________________________

Additional Financial Party Information

Name(s):_____________________________________

Relationship:__________________________________

Home address: ________________________________

____
City State Zip

Best Contact Number: (_____)___________________

Additional Phone Number: (______)_______________

Email:____

Employer: _____________________________________

Dental Insurance: (Please complete thoroughly)

Primary Insurance:_____________________________

Name of Policy Holder: _________________________

ID/Policy #:_______________ SSN: _______________

Group #: ____________________________________

Claims Address: _______________________________

____

Claims Phone #:_______________________________

Date of Birth: _________________________________

Employer:_____________________________________

See back for health history information

What Are the Main Orthodontic Concerns?

____

____

____

Has your child ever had or been evaluated for orthodontic treatment?
❑ No ❑Yes When? ____________________

Have there been any injuries to the face, mouth, teeth or chin? ❑ No ❑Yes When? _________________

List any musical instruments played:_________________
____

Have adenoids or tonsils been removed? ❑No ❑Yes

Does your child have any missing or extra permanent teeth? ❑ Yes ❑ No

Has your child ever had any pain or tenderness in his/her jaw joint (TMJ/TMD)? ❑ No ❑Yes
Explain:____

Does your child brush his/her teeth daily?
❑ Yes ❑ No
Does your child floss his/her teeth daily?
❑ Yes ❑ No

Does your child have any of the following habits?

Y N Thumb/Finger Sucking	**Y N** Mouth Breather
Y N Lip Sucking/Biting	**Y N** Speech Problems
Y N Clenching/Grinding	**Y N** Nail Biting

Child's Physician: _________________________________

Phone #: (______)__________________________________

Date of last visit:_____/_____/_____

Reason for visit:__________________________________

Is your child currently under routine care of a physician?
❑Yes ❑No
If yes, please explain:______________________________

Has puberty begun? ❑Yes ❑No

If a girl, has menstruation begun? ❑Yes ❑No

Is your child taking any prescription/over-the-counter drugs? ❑Yes ❑No
If yes, please list:_________________________________

Is your child 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 all drugs your child is allergic to:

____

Does your child have or ever had any of the following diseases or medical problems?

Y N Heart Murmur	**Y N** Congenital Heart Defect
Y N Cancer	**Y N** Convulsions/Epilepsy
Y N Diabetes	**Y N** Abnormal Bleeding
Y N Rheumatic Fever	**Y N** Hearing Impairment
Y N HIV+/AIDS	**Y N** Any Operations?
Y N Hemophilia	**Y N** Any stays in a hospital?
Y N Asthma	**Y N** Kidney/Liver Problems
Y N Hepatitis	**Y N** Handicaps/Disabilities
Y N Tuberculosis	

- ❖ **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 child's medical status.**
- ❖ **I hereby authorize the release of any information pertaining to my child's 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