Adult Information Form

Dr. Matthew J. Pershing
Member American Association of Orthodontics
Certified American Board of Orthodontics

www.pershingortho.com

815 N. Marian Road, Hastings, NE 68901 • (402) 462-4173 • 1004 N. Diers Avenue, Grand Island, NE 68803 • (308) 382-3222

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset.

PLEASE FILL OUT THIS FORM COMPLETELY. The better we communicate, the better we can care for you. EXAMINATION DATE ________ TIME ________

1. ABOUT YOU

Name: ______________________________
Last First M.I. Mr. Mrs. Ms. Dr.

I prefer to be called: ______________ ❑ Male ❑ Female

Birthdate: ____________ Age: ____ SS#: ____________

Home Address: ______________________________
Street

____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home #: ____________ Cell #: ____________

Email: ______________________________

Employer: ______________________________

Employer's Address: ______________________________

Work #: ____________ Ext. ________ DL: ________

How long there? ________ Occupation: ____________

Whom may we thank for referring you?: ____________

Other family members seen by us: ____________

General Dentist: ______________________________

Last visit date: ______________________________

2. SPOUSE INFORMATION

His/Her Name: ______________________________

Employer: ______________________________

Work #: ____________ Ext. ________

SS#: ____________ Birthdate: ___/___/___

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name: ______________________________

Work #: ____________ Ext. ________

Home #: ______________________________

Billing Address: ______________________________

Relation: ____________ SS#: ____________

Employer: ____________ DL #: ____________

3. ORTHODONTIC INSURANCE

PRIMARY

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone: ______________________________

Group # (Plan, Local, or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ___/___/___ Insured's SS#: ____________

Insured's Employer: ______________________________

SECONDARY

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone: ______________________________

Group # (Plan, Local, or Policy #): ____________

Insured's Name: ____________ Relation: ____________

Insured's Birthdate: ____________ Insured's SS#: ____________

Insured's Employer: ______________________________

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEAR YOU THAT WE SHOULD CONTACT?

His/Her Name: ______________________________

Relation: ______________________________

Work #: ____________ Home #: ____________

4. MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ______________________________

Phone #: ______________________________

Date of last visit: ______________________________

4. MEDICAL HISTORY (continued)

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

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

Please explain: ______

Are you taking any prescription/over-the-counter drugs? ❑Yes ❑ No

Please list each one: ______

For Women: Are you taking birth control pills? ❑Yes ❑ No

Are you pregnant? ❑Yes ❑No Week #: ______

Are you nursing? ❑Yes ❑No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N	Anemia/Radiation Treatment	Y N	Heart Surgery/Pacemaker
Y N	Artificial Bones/Joints	Y N	Hemophilia/Abnormal Bleeding
Y N	Artificial Valves	Y N	Hepatitis
Y N	Asthma/Arthritis	Y N	High/Low Blood Pressure
Y N	Blood Transfusion	Y N	HIV+/AIDS
Y N	Cancer/Chemotherapy	Y N	Hospitalized for Any Reason
Y N	Congenital Heart Defect	Y N	Kidney Problems
Y N	Diabetes/Tuberculosis (TB)	Y N	Mitral Valve Prolapse
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Drug/Alcohol Abuse	Y N	Rheumatic/Scarlet Fever
Y N	Emphysema/Glaucoma	Y N	Severe/Frequent Headaches
Y N	Epilepsy/Seizures/Fainting Spells	Y N	Shingles
Y N	Fever Blisters/Herpes	Y N	Sinus Problems
Y N	Heart Attack/Stroke	Y N	Ulcers/Colitis
Y N	Heart Murmur	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

______

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

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

Please list any other drugs that you are allergic to: ______

______

5. DENTAL HISTORY

WHAT ARE THE MAIN CONCERNS YOU WOULD LIKE ORTHODONTICS TO ADDRESS?

______

______

Have you ever had or been evaluated for orthodontic treatment ❑Yes ❑No

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

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑Yes ❑No

Your current dental health is? ❑Good ❑Fair ❑Poor

Do you like your smile? ❑Yes ❑No

Do your gums ever bleed? ❑Yes ❑No

Have you ever had an injury to your: ❑Mouth ❑Teeth ❑Chin

Do you have any speech problems? ______

______

Do you generally breathe through your mouth?
Awake: ❑Yes ❑ No Asleep: ❑ Yes ❑ No

Do you have any missing or extra permanent teeth? ❑Yes ❑No

I understand that the information I have given today is correct to the best of my knowledge I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

______
Signature Date

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY!

This office reserves the right to verify the credit status of potential patients and/or spouses of patients prior to extending credit for treatment fees, and may, at the discretion of the office, use the services of one or more credit reporting companies.

Signature: ______ Date: ______

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

— — — OFFICE USE ONLY — — —

Treatment Coordinator Notes: Initials: ______ Date: ______

______

______

______

______