Dr. Robert J. Shelling, DMD, PA
Orthodontics for Children & Adults
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www.shellingortho.com

When You're Smiling, We're Smiling!

Patient Information

Date: ______________________

Patient's Name: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

Home Phone: ______________ Cell Phone: ______________ E-mail: ______________

Date of Birth:______________ Age:________ Sex: ________

School: ______________________

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

General Dentist: ______________________ City: ______________

Siblings: Name: ______________ DOB: ______________ Grade: ________

Name: ______________ DOB: ______________ Grade: ________

Name: ______________ DOB: ______________ Grade: ________

Name: ______________ DOB: ______________ Grade: ________

Responsible Party Information

Father's Name: ______________________

Address: ______________________ City: ______________ Zip: ________

Home Phone: ______________ Work Phone:______________ Cell Phone: ______________

E-mail: ______________ Social Security #: ______________ DOB:______________

Employer: ______________________ Occupation: ______________________

Mother's Name: ______________________

Address: ______________________ City: ______________ Zip: ________

Home Phone: ______________ Work Phone:______________ Cell Phone: ______________

E-mail: ______________ Social Security #: ______________ DOB:______________

Employer: ______________________ Occupation: ______________________

Person financially responsible for this Account: ______________________

I authorize ______________________ to accompany my child to Dr. Shelling's office for a dental visit.

Signature:______________________ **Date:** ______________

Orthodontic Insurance Information

Policy Holder's Name: ______________ Social Security #:______________ DOB:______________

Insurance Company: ______________ Group #: ______________ Phone: ______________

Do you have dual coverage? ❑ Yes ❑ No

Second Insurance Name: ______________ Social Security #:______________ DOB:______________

Emergency Information

Name of Contact Person Relationship: ______________________________

Home Phone: ____________________ Work Phone:____________________ Cell Phone: ____________________

Medical History

Physician's Name: ______________________________

Does patient have a history of major illness or hospital stay? ______________________________

If so, which of the following the patient has been treated for:

❑ Anemia	❑ Diabetes	❑ Heart Problems	❑ Rheumatic Fever
❑ Arthritis	❑ Dizziness	❑ Hepatitis	❑ Sinus Problems
❑ Asthma	❑ Epilepsy	❑ Herpes	❑ Tuberculosis
❑ Blood Disease	❑ Glaucoma	❑ HIV + / - AIDS	❑ Other ____________
❑ Cold Sores	❑ Hearing Loss	❑ Kidney / Liver	____________

Please Explain: ______________________________

____

Have your tonsils and adenoids been removed? ____________________ If so, what age?__________

List any drugs or medications now being taken: ______________________________

List any allergies or sensitivities (Drug, Latex, Metal, Plastic, Other) ______________________________

Has patient reached puberty? GIRL – Started Menstruation ______________________________

BOY – Voice Changed / Facial Hair ______________________________

Dental History

Have there been injuries to the face, mouth or teeth?______________________________

Has the patient ever sucked a thumb or finger? Until what age? ______________________________

Is the patient a mouth breather?______________________________

Does the patient have a tongue thrust? ______________________________

Have you been informed of any missing or extra permanent teeth? ______________________________

Has an orthodontist been consulted previously?______________________________

Has either parent or siblings had orthodontic treatment?______________________________

Has your child ever experienced pain / discomfort in their jaw (TMJ / TMD)? ______________________________

WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH? ______________________________

____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

Signature: ______________________________ Date: ____________________

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