Dr. Robert J. Shelling, DMD, PA
Orthodontics for Children & Adults
19615-33 S. State Road 7 • Boca Raton, FL 33498
Phone: (561) 477-4844 • Fax: (561) 750-1021
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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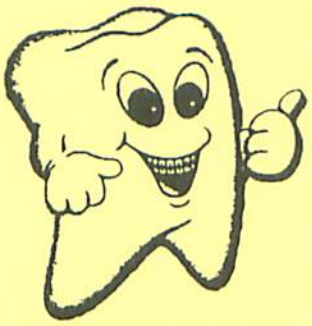
Personal Questions to help Dr. Shelling and his staff to get to know you better! Answer as many as you would like!

Do you have a Nickname? _____
What is your favorite thing to do? _____
Whats your favorite sport? _____
What pets do you have? _____
Do you have any hidden talents? _____
Any obsessions? _____
Any fears? _____
What are your future goals? _____
What is your dream job? _____



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Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I _____, have reviewed/received
(Parent Name)

a copy of Shelling Orthodontics Notice of Privacy Practices.

_____ _____

Signature of Patient Guardian Date

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