Dr. Robert J. Shelling, DMD, PA
Orthodontics for Children & Adults
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When You're Smiling, We're Smiling!

Adult Patient Information

Date: _____

Patient's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: _____

Employer: _____ Occupation: _____

Spouse: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____ How Long? _____

General Dentist: _____ City: _____

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

Person financially responsible for this account: _____

Orthodontic Insurance Information

Policy Holder: _____

Social Security #: _____ DOB: _____

Insurance Company: _____ Group No: _____ Phone: _____

Do you have dual coverage? ❑ Yes ❑ No

Policy Holder: _____

Social Security #: _____ DOB: _____

Emergency Information

Name of Contact Person: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail: _____

Medical History

Are you in good health? _____

Physician's Name: _____ City: _____

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: _____

Please give reason _____

Are you taking any medications for osteoporosis? If so, what & for how long? _____

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

Dental History

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

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

Do you have any speech problems? _____

Do you 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? _____

Have you 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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