



**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:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Herpes	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> HIV + / - AIDS	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> 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: \_\_\_\_\_