Dr. Nancy Shackleton

SPECIALIST IN ORTHODONTICS

3019 Preston Highway
Louisville, KY 40217
502-637-2900

1006 Leawood Drive
Frankfort, KY 40601
502-223-0211

Information Update

Patient Name:_____ Date of Birth:_____

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

Phone Number Home_____ Cell_____

Email Address_____ Social Security #_____

Responsible Party Name:_____ Date of Birth:_____

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

Phone Number Home_____Cell_____

Email Address_____ Social Security# _____

Place of Employment:_____ Work Number: _____

Address: _____

GENERAL DENTIST_____

DENTAL INSURANCE INFORMATION

Insurance Company(1)_____ (2)_____

Insurance Phone Number_____ _____

Insured Social Security Number_____ _____

Insured Date of Birth_____ _____

I acknowledge review of HIPPA policy information:_____

Signature

MEDICAL INFORMATION

Do you have or have you ever had the following:

Joint replacement	yes / no	Arthritis	yes/ no
Heart Problem (murmur, angina, heart attack, heart failure, rhythm problem	yes / no	Thyroid Disease	yes/ no
Rheumatic Fever	yes / no	Diabetes	yes/ no
High blood pressure	yes/ no	Stomach / Intestinal disease	yes/ no
Lung disease	yes/ no	Kidney Disease	yes/ no
Tuberculosis (TB)	yes/ no	Chemical Dependence	yes/ no
Liver Disease	yes/ no	HIV infection/AIDS	yes/ no
Hepatitis	yes/ no	Blood Disorder/Prolonged Bleeding	yes/ no
Tumors/Cancer	yes/ no	Radiation Therapy	yes/ no
Nervous Psychiatric Disorders	yes/ no	Mononucleosis	yes/ no
Sinus, nasal or ear disease	yes/ no	Epilepsy/Seizures	yes/ no
Eye Problems	yes/ no	Smoking	yes/ no
Allergy to Nickel	yes/ no	CURRENTLY PREGNANT	yes/ no
Allergy to Latex	yes/ no	Adolescent Puberty Reached	yes/ no
Allergy Medications	yes/ no		

List Allergies_____

Other Concerns :_____

CURRENT MEDICATIONS:_____

_____

DENTAL HISTORY

Has patient seen Dentist in last 6 months	yes/ no	Thumbsucking habit	yes/ no
Did dentist refer for treatment?	yes/ no		
Pain, Clicking , Jaw Joint or ear pain	yes/ no	Mouthbreather	yes/ no
Facial injuries/fractures	yes/ no	Clenching /Tooth Grinding habit	yes/ no
Missing or extra teeth	yes/ no	History of Biteguard Wear	yes/ no
"Gum" Problems	yes/ no	Tongue Thrust Habit	yes/ no
Tonsils and/or Adenoids removed	yes/ no	Speech Problems	yes/ no

Is patient feeling that improvements can be made for smile or bite? yes/ no

Attitude toward treatment: Circle one

- Eager/Excited
- Will tolerate to reach goals
- Antagonistic

Previous Orthodontic Treatment in our office or another? yes/no

Other family members who have had orthodontic treatment?

_____

What would you like Orthodontic treatment to accomplish?_____

Emergency Contact Information Name_____ Phone_____

Patient/Parent Signature (if under 18 years) **Date**