Stan D. Drabik, D.D.S.
Orthodontic Specialist for Children & Adults

Today's Date ___________

Thank you for selecting our ortho healthcare team! We will strive to provide you with the best possible ortho care. To help us meet all your dental healthcare needs, please fill out this form completely in ink.

Patient Information (CONFIDENTIAL)

Email address ____

Name ____ Birthdate ________________ SS# ________________

Address ____ City ________________ State ______ Zip __________

Home Phone ____ Cell Phone ________________________________

Check Appropriate Box ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

If Student, Name of school/College ________________________ City ________________ State ______ ❑ Full Time ❑ Part Time

Patient or Parent/Guardians' Employer ____

Business Address ____ City ________________ State ______ Zip __________

Spouse or Parent/Guardian's Name ________________________ Employer ________________ Work Phone ______________

Whom May We Thank for Referring You? ____

Person to Contact in Case of Emergency ____ Phone ________________

Responsible Party

Name ____ Birthdate ________________________ Relationship to Patient ______________

Address ____ Home Phone ______________

City ________________ State ________________ Zip ________________ Cell Phone ______________

Employer ____ Work Phone ______________ SS# ________________

Is this Person Currently a Patient in our Office? ❑ Yes ❑ No

For your convenience, we offer the following methods of payments. Please check the option you prefer. Payment in full at each appointment

❑ Cash ❑ Personal Check ❑ Credit Card ❑ Visa ❑ Master Card ❑ I wish to discuss the office's payment policy

Dental Insurance Information

Name of Insured ____ Relationship to Patient ________________

Birthdate ______________________ SS# ____

Name of Employer ____ Union or Local # ___________ Work Phone ______________

Address of Employer ____ City ____________________ State _______ Zip __________

Insurance Company ____ Group # ________________ Policy/ID# ________________

Ins. Co. Company ____ City ____________________ State ________ Zip __________

Insurance Telephone # ____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ Yes ❑ No ***IF YES, COMPLETE THE FOLLOWING:***

Name of Insured ____ Relationship to Patient ______________

Birthdate ______________________ SS# ____

Name of Employer ____ Union or Local # __________ Work Phone ______________

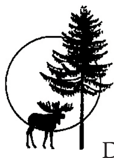
Address of Employer ____ City ____________________ State _______ Zip ________

Insurance Company ____ Group # ________________ Policy/ID# ________________

Ins. Co. Company ____ City ____________________ State _______ Zip ________

Insurance Telephone # ____

OVER PLEASE



Medical History

Do you have a Dentist? ❑ Yes ❑ No

Dentist's Name: ___________________________________

Phone # (____) _____________ Date of last visit: ________________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ____

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No

Please list each one:____

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week # ____________

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following disease or medical problems?

Y N Abnormal Bleeding	Y N Hemophilia
Y N Anemia	Y N Hepatitis
Y N Artificial Bones / Joints/ Valves	Y N High / Low Blood Pressure
Y N Asthma / Arthritis	Y N HIV+ / AIDS
Y N Blood Transfusion	Y N Hospitalized for Any Reason
Y N Cancer / Chemotherapy	Y N Kidney Problems
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Radiation Treatment
Y N Drug / Alcohol Abuse	Y N Rheumatic / Scarlet Fever
Y N Emphysema	Y N Severe / Frequent Headaches
Y N Epilepsy / Seizures / Fatigue	Y N Shingles
Y N Fever Blisters / Herpes	Y N Sickle Cell Disease / Traits
Y N Glaucoma	Y N Sinus Problems
Y N Heart Attack / Stroke	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers / Colitis
Y N Heart Surgery / Pacemaker	Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y N Aspirin	Y N Dental Anesthetics	Y N Penicillin
Y N Any Metals/Plastics	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other

Please list any other drugs / materials that you are allergic to: ________

____

Any other condition that may impact your care _____________________________

Dental History

What are the main concerns that you would like orthodontics to accomplish?

____

____

Have you ever had or been evaluated for orthodontic treatment? ❑ Yes ❑ No

Have you ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in you jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No Gums ever bleed? ❑ Yes ❑ No

Have you ever had an injury to your: Mouth Teeth Chin (please circle)

Do you have any speech problems?_______________________________

Do you generally breathe through your mouth? ❑ Yes ❑ No

If yes, please circle: While Awake? While Asleep?

Do you have any missing or extra permanent teeth ❑ Yes ❑ No

Have you ever taken Phen-Fen (Also known as Redux or Pondimin) ❑ Yes ❑ No

If yes, when? ____

Do you smoke or use tobacco in any form? ❑ Yes ❑ No

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

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. The information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers. .
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature: ____

Relationship to Patient: ____

Date: ____