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

Today's Date ______________

Welcome to our practice! We strive to make every child's visit pleasant and comfortable. To help us meet all of your child's healthcare needs, please fill out this from completely in ink.

Your Child

Child's Name ______________

Prefer to be called ______________ Sex ______

Birthdate ______________ Age ______

School ______________ Hobbies ______________

List Brothers/Sisters with Age ______________

____

Child's Home Address ______________

City ______________ State ______________ Zip ______________

Phone ______________

Responsible Party

Name ______________

Relationship ______________

Address ______________

City ______________ State ______________ Zip ______________

SS# ______________

Date of Birth ______________

Whom may we thank for referring you?

____

Who is responsible for making appointments?

Name ______________

Cell Phone ______________ Work Phone ______________

Home Phone ______________

Ext. ______________ Email ______________

Mother ❑ Mother ❑ Stepmother ❑ Guardian

Name ______________

Address ______________

Home Phone ______________ Cell Phone ______________

Work Phone ______________ Ext. ______________

Employer ______________

Occupation ______________

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Father ❑ Father ❑ Stepmother ❑ Guardian

Name ______________

Address ______________

Home Phone ______________ Cell Phone ______________

Work Phone ______________ Ext. ______________

Employer ______________

Occupation ______________

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Primary Dental Insurance

Insured's Name ______________

Relationship ______________

Birthdate ______________ SS# ______________

Employer ______________

Occupation ______________

Insurance Company ______________

Group # ______________ Insurance ID ______________

Insurance Co. Address ______________

City ______________ Sate ______________ Zip ______________

Insurance Telephone # ______________

Additional Dental Insurance

Insured's Name ______________

Relationship ______________

Birthdate ______________ SS# ______________

Employer ______________

Occupation ______________

Insurance Company ______________

Group # ______________ Insurance ID ______________

Insurance Co. Address ______________

City ______________ Sate ______________ Zip ______________

Insurance Telephone # ______________

Financial Arrangements

For your convenience, we offer the following methods of payment:

Cash, Personal Check, Visa, MasterCard, Discover, and American Express

Over Please

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

____

____

Has your child ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

List any musical instruments played: ____________________

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has your child ever had any pain / tenderness in his /her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does your child brush his / her teeth daily? ❑ Yes ❑ No

Floss his / her teeth daily? ❑ Yes ❑ No

Child's Dentist:____

Phone # (___) ____________ Date of Last Visit: _______

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

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls) ❑ Yes ❑ No

Please describe your child's current physical health:
❑ Good ❑ Fair ❑ Poor

Please list all drugs that your child is currently taking: _________

____

____

Please list all drugs / materials that your child is allergic to:

____

____

Any other condition that may impact your care________________

Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N ADD / ADHD
Y N Allergies to any Drugs
Y N Allergic to Latex
Y N Allergic to Metals
Y N Allergic to Plastic
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Bones / Joints/ Valves
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions / Epilepsy
Y N Diabetes
Y N Handicaps / Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+/ AIDS
Y N Kidney / Liver Problems
Y N Lupus
Y N Rheumatic / Scarlet Fever
Y N Tuberculosis (TB)

Please list any medical problems that your child has / or has had: ____

____

____

Has your child ever experienced any of the following?

Y N Clenching / Grinding Teeth
Y N Lip Sucking / Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/ Finger Sucking
Y N Tongue Thrust

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: ____

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.

____
Signature of parent or guardian Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

____
Signature Date

The Parent or Guardian who accompanies the child is responsible for payment
Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, and the ADA.