

WELCOME TO OUR OFFICE

Date _____

Patient's Full Name _____ Birthday _____ Sex _____

Address, City, State, Zip _____ Phone _____

Occupation _____ Employer _____ Bus Phone _____ Cell Phone _____

Spouse _____

Occupation _____ Employer _____ Bus Phone _____ Cell Phone _____

Person Responsible for Account _____

Preferred Billing Address _____ City, State, Zip _____

Name of Insurance Carrier _____ Insured Name _____

Insured SS# _____ DOB _____ Relationship to Patient _____

Patient's General Dentist _____ Date of Last Check-up _____

Who can we thank for referring you? _____

Please name any other family members seen by this office _____

HEALTH HISTORY

Have you had previous orthodontic treatment, and if so, when? _____

Any specific orthodontic concerns: _____

Physician's Name _____

Describe any problem in your general health within the past 5 years _____

Are you under a physician's care now, if so, for what? _____

What tablets, pill or liquids do you take? (aspirin, vitamins, tonics, etc.) _____

Are you undergoing radiation treatment for a tumor or other growth _____

Are you currently taking any medications for osteoporosis or osteopenia? _____

(Actonel, Boniva, Didronel, Fosamax, Skelid, Aredia, Bonefos, Zometa, Reclast)

Women: Are you pregnant? _____

Do you have artificial implants or devices? _____

Have you had an injury to the face, jaws, or teeth, and if so, explain? _____

Are you sensitive to any of the following: (circle) Penicillin, codeine, latex, aspirin, anesthetics, metals (nickel) or other drugs. _____

Have you ever had any of the following conditions? Please circle all that apply.

- | | | |
|--|---------------------------|------------------------------------|
| Rheumatic fever or rheumatic heart disease | Fainting Spells, seizures | Diabetes |
| Heart trouble, heart attack | Hepatitis, jaundice | Tuberculosis, other lung ailments |
| High blood pressure, stroke | HIV, AIDS | Thyroid Problems |
| Blood disorders, anemia | Immune disorders | Persistent cough, coughed up blood |
| Abnormal bleeding, prolonged bleeding | Liver disease | Kidney disease |
| Asthma, hay fever | Cancer | Psychiatric / nervous problems |

Do you have any disease, condition or problem not listed above that you think the doctor should know about? _____

Kelly A. Goeckner DDS, MS
I authorize Miller W. Gibbons, DDS to obtain/release any pertinent medical, dental, insurance/financial information necessary in order to properly prepare an orthodontic treatment plan. I also acknowledge receipt of the office privacy policy.

Email _____ Signature _____



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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

Address: _____

I have reviewed/received a copy of the **Notice of Privacy Practices** for Goeckner Orthodontics.

Signature of Patient or Parent/Guardian _____

Date _____

Authorization to Release Protected Health Information

Kelly Goeckner DDS, MS (DBA: Goeckner Orthodontics) is authorized to release protected health information about the above named patient in the following manner and to identified persons:

Information to Release (select all that apply):

Appointments Financials Clinical Records

Dental and/or Medical Insurance Company	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Communication to referring Doctors	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Voicemail	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Email (If not encrypted, there is a risk it could be accessed inappropriately)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Persons Listed Below:	Relationship to Patient:			
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Rights:

- I have the right to revoke this authorization at any time with notice to the office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by patient and/or parent/guardian.

Signature of Patient or Parent/Guardian _____

Date _____

Goeckner Orthodontics

COVID-19 Pandemic Dental Treatment Consent Form

Even after following protocols set by the American Dental Association and our state's dental association, it is still possible to contract COVID-19 while at a dental office. We are following all guidelines to minimize the risk of transmission.

- I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious. _____ (Initial)
- I understand that – due to the frequency of visits of other dental patients, the characteristics of the COVID-19 virus, and the characteristics of dental procedures – I have an elevated risk of contracting the COVID-19 virus simply by being in a dental office. _____ (Initial)
- I confirm that I am not presenting any of these COVID-19 symptoms: _____ (Initial)
 - Fever
 - Shortness of breath
 - Dry cough
 - Runny nose
 - Sore throat
- I confirm that I have not been in contact with a person who has been diagnosed with COVID19 within the past 14 days. _____ (Initial)
- I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with dentistry. _____ (Initial)
- I verify that I have not traveled outside the United States in the past 14 days. _____ (Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days. _____ (Initial)

Printed name: _____
(Patient)

Date of birth: _____
(Patient)

Signature: _____
(Patient or legal guardian)

Today's date: _____