WELCOME TO OUR OFFICE

Date _____

Patient's Full Name _____ Birthday _____ Sex _____

Address, City, State, Zip _____ Phone _____

Father _____ Address _____ Cell Phone _____

Occupation _____ Employer _____ Bus Phone _____

Mother _____ Address _____ Cell Phone _____

Occupation _____ Employer _____ Bus Phone _____

Person Responsible for Account _____

Preferred Billing Address _____ City, State, Zip _____

_____

Name of Insurance Carrier _____ Insured Name _____

Insured SSN# _____ 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 Address _____ _____

Signature

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: _____

Goeckner Orthodontics

Kelly A. Goeckner DDS, MS

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Wilson, NC 27896

P: 252-237-9999
F: 252-237-7129

www.goecknerorthodontics.com

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	☒	☒	☒
Communication to referring Doctors	☒	☒	☒
Voicemail	☐	☐	N/A
Email	☐	☐	☐

(If not encrypted, there is a risk it could be accessed inappropriately)

Other Persons Listed Below:	Relationship to Patient:			
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐

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