GOEBEL PEDIATRIC DENTISTRY

Patient's Name: _____ Nickname: _____ Age: _____

Sex: _____ Date of Birth: _____ Place of Birth: _____

Patient's Address: _____ Home Phone: _____
Street City State Zip
Cell Phone: _____

Father's Name: _____ Social Security #: _____

His Address: _____ Date of Birth: _____
Street City State Zip

Where Employed: _____ Phone: _____

Mother's Name: _____ Social Security #: _____

Her Address: _____ Date of Birth: _____
Street City State Zip

Where Employed: _____ Phone: _____

Phone Numbers for confirmation of appointment: _____

With whom does patient live: _____

Other children in family who have received dental care in this office: _____

Dental Insurance or Medicaid? Yes_____ No_____ Insurance Company:_____

Insurance/Medicaid ID Number: _____ Subscriber Name and DOB: _____

Child's Physician:_____ Family Dentist: _____

Whom may we thank for referring you to our office: _____
(Doctor) or (Parent) or (Parent)

HEALTH HISTORY

	Yes	No
Is your child in good health?	_____	_____
Does your child have regular medical examinations?	_____	_____
Is your child up to date with immunizations?	_____	_____
Is this your child's first dental visit?	_____	_____

Is your child a thumb/finger sucker? _____ Use a pacifier? _____

If your child was bottle fed at what age was it discontinued? _____

Check any of the following that may pertain to your child:

___ Rheumatic fever	___ Bleeding disorder	___ Lung problem	___ Mental disorder
___ Heart Condition	___ Cerebral Palsy	___ Brain injury	___ Emotional disorder
___ Speech disorder	___ Liver	___ Epilepsy	___ Tuberculosis
___ Hearing disorder	___ Kidney	___ Hepatitis	___ Sickle Cell Anemia
___ Vision disorder	___ Asthma	___ Diabetes	___ Autism
___ Nervous disorder	___ Allergies		___ Other

Is your child presently taking any medicine? _____ _____ _____
(Name of Medication)

Has your child experienced any unfavorable reaction to medicine?
(Such as penicillin, aspirin, xylocaine) _____ _____

Is your child allergic to any drug or food? _____ _____
If so, what? _____

Is your child presently undergoing medical treatment? _____ _____

Has your child ever been hospitalized since birth? _____ _____
If so. Date: _____ Reason: _____

Has your child ever had an unfavorable experience in dental office? _____ _____

Date of your child's last dental care: _____

Does your child have a toothache? _____

Purpose of this appointment: _____

Thank you for your help. If there is any information that you may think might be of value to us in treating your child, please feel free to comment.

PERMISSION: Since _____ is a minor, it becomes necessary that signed permission be obtained before any and/all necessary dental service can be performed by Goebel Pediatric Dentistry. Authorization is hereby granted as such. Furthermore, I will be responsible financially for any bill incurred on this patient for dental treatment.

Signed: _____ Date: _____ Relationship:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgment****

I, _____ , have received a copy of this office's Notice of Privacy Practices

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual Refused to Sign
- ☐ Communications Barriers Prohibited obtaining the acknowledgment
- ☐ An Emergency Situation Prevented Us From Obtaining Acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____