WELCOME TO OUR DENTAL OFFICE

THANK YOU FOR SELECTING ROTHBAUER DENTAL

Patient's NAME_______________________________________BIRTHDATE_________________________________

(*Please circle*) single married divorced widowed separated SEX: Male Female

ADDRESS____Email__________________________

City/State/Zip____

Home Phone__________________________Cell Phone w/Provider____

Work Phone___________________________Social Security #____

Occupation/ College_______________________Employer Address____

PRIMARY DENTAL INSURANCE INFORMATION:

Insurance company________________________________GROUP____

Subscriber' SS#____________________________________ Birthdate______________________________________

Subscriber's NAME and address ____

Subscriber's relationship to patient (*Please circle*) Self Spouse Child

SECONDARY Dental Insurance Information____

DENTAL HISTORY:

WHAT IS THE REASON FOR TODAY'S VISIT?____

What DON'T you like about your teeth? ____

Would you like your **teeth whiter or straighter?** ____

Date of last dental visit________________________ Name of last dentist__________________________________

What level of care are you most interested in? (**A**)“Just patch it” (**B**)“Average Joe” (**C**)“Ideal / The Best”

Please CIRCLE if you **now** have or **ever** had any of the following:

Grind Your Teeth	Periodontal treatment	Tooth Sensitivity	Snore
Clench Your Teeth	Bleeding gums	Bad Breath	Sleep Apnea
Clicking or Popping Jaw	Sores in your mouth	Head or Neck Trauma	Tobacco

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? Please give name and phone number:

RELATIVE____

NON RELATIVE____

How did you hear about us? ____