WELCOME TO ROTHBAUER DENTAL, We are grateful you've chosen us!

Patient's NAME: ____________________________ BIRTHDATE: _______________SEX: Male Female Non-Binary

ADDRESS: ____

City/State/Zip: ____

Home Phone: ___________________________Cell Phone w/PROVIDER: ____________________________________

Work Phone: ____________________________Email: ____

Occupation/College: _________________________________

Employer with Address: ____

PRIMARY DENTAL INSURANCE INFORMATION:

Social Security #: _____________________________

Insurance company: ____________________________ GROUP: ____________________________

Subscriber's SS#: ______________________________ Birthdate: ___________________________

Subscriber's NAME and address: ____

Subscriber's relationship to patient (circle): Self Spouse Dependent

SECONDARY Dental Insurance Information:____

DENTAL HISTORY:

REASON FOR TODAY'S VISIT? _______________________________

What DON'T you like about your teeth? _________________________________

Would you like your teeth whiter or straighter? ___________________________

Are you Interested in braces or clear aligners? ___________________________

Date of last dental visit: ______________________ Name of last dentist: __________________

What level of care are you most interested in? (circle) "Just patch it" "Average Joe" "Ideal / The Best"

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

Grinding/Clenching

Bad Breath

Snoring/Sleep Apnea

Head/Neck Trauma

Clicking/Popping

Mouth Sores

Periodontal Treatment

Tooth Sensitivity

Bleeding Gums

Gum Surgery

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

Relative: ____ Non-Relative: ____

How did you hear about us? ____

ALLERGIES? (Circle) YES / NO PLEASE LIST____
(Penicillin, Latex, Sulfites, etc...)

CIRCLE IF YOU HAVE NOW OR HAVE EVER HAD ANY OF THE FOLLOWING:

AIDS/HIV	ADD/ADHD	Asthma	Cold Sores
Epilepsy	Lung Problems	Kidney Problems	Bleeding Problems
Diabetes	TB	Anxiety	Chicken Pox
Implants	Sinus Issues	Thyroid	Ulcers
Blood Pressure	Mitral Valve Prolapse	Stroke	Hives
Cancer	Hepatitis	Fluoride Supplement	Arthritis
Bisphosphonates	Osteoporosis	Heart Murmur	COVID
Pacemaker	Heart Issue	Blood Issue	
Artificial Valves, Limbs, Joints	Ruematic fever	Fainting	Chemical Dependency

Do you currently use tobacco or tobacco-like products (Vape)? ____________
Do you use any recreational drugs? ___________________________________
Are you currently using hormonal or contraceptive medication? ___________________________
If pregnant, when is your due date? _______________________

Is there anything you want us to know about your health? _________________

AUTHORIZATION, RELEASE AND CONSENT FOR TREATMENT:

I certify that I have read and answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such dental care, to third-party payers and/or health practitioners. I hereby give my consent for any preventive and/or restorative treatment that the dentist and I have deemed necessary. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient/Guardian Signature____ Date____________________

PLEASE LIST ALL MEDICATIONS THAT YOU TAKE OR PROVIDE A CURRENT COPY TO ATTACH:

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HEALTH HISTORY REVIEW SIGNATURE AND DATE BY DR/RDH: