

Robert J. Bauder, D.M.D., P.C.

36275 Kenai Spur Highway • Soldotna, Alaska 99669

907.262.8404

PATIENT INFORMATION

Driver Lic. #: _____ SSN: ____ - ____ - ____
Legal Name: _____
I Prefer to be Called: _____
Address: _____
E-mail: _____
Sex: M / F Age: _____ Birthday: _____
Occupation: _____
Employer: _____
Employer Address: _____
Employer Phone: (_____) _____
Spouse's or Parent Name: _____
Birth date: _____ SSN: ____ - ____ - ____
Occupation: _____
Spouse's or Parent Employer: _____
Whom may we thank for referring you?: _____

DENTAL INSURANCE

Insurance Subscriber: _____
Relationship to Patient: _____
Employer: _____
Insurance Co.: _____
ID #: _____
Is patient covered by additional insurance? Y / N
Subscriber's Name: _____
Birth date: _____ SSN: ____ - ____ - ____
Relation to Patient: _____
Secondary Insurance Co.: _____
ID #: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with _____.
I assign directly to Dr. Bauder all insurance benefits. I understand that I am financially responsible for all charges. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

PHONE NUMBERS

Home: (_____) _____ Work: _____ X _____

Cell: (_____) _____

Best time & place to reach you: _____

Emergency Contact: _____

Name: _____ Relationship: _____ Number: _____

DENTAL HISTORY

Former Dentist: _____

Do you like your smile?

Yes

No

Date of last visit: _____

Do you have discolored teeth?

Yes

No

Date of last X-rays: _____