Sign up for GIVE KIDS A SMILE 2013

To treat children in your office

FEBRUARY 1-28, 2013

Title:
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss

Degree: _____

First Name: _____ **Last Name**: _____

Position:
☐Dentist ☐Hygienist ☐Assistant ☐Assistant Student

Address:
Office: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

How many patients would like to see in your office? _____

How would like the patient to contacted for an appointment with you?
☐ Have the patient call our office
☐ We will contact the patient

What is the youngest age group you would like referred to your office?
☐ Any ☐ 7-9
☐ 4-6 ☐ 10-12

Is your office able to accept Spanish speaking patients?
☐ Yes ☐ No

Please mail to:
Angelica Rohner Pediatric Dentistry
c/o Angelica Rohner
2045 Medical Center Drive, Suite 21
Birmingham, AL 35209
205-870-0892

Please fax to:
Angelica Rohner Pediatric Dentistry
c/o Angelica Rohner
205-263-9710

Please email to:
arohner@drrohner.com