ROGERS DENTAL CENTER

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you!

ABOUT YOU: **TODAY'S DATE:** _____

Name: _____ _____ _____ (_____)
Last First MI Preferred-name

O Female **O** Male Birth Date _____ SS# _____

O Single **O** Married **O** Divorced **O** Widowed **O** Separated

Address: _____

_____ _____ _____
City State Zip Code

Email Address: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Best way to confirm appointments (mark all that apply): **O** Phone call **O** Text **O** Email

Employer: _____ City: _____

How long have you been there? _____ Occupation: _____

Who may we thank for referring you? _____

Other family members seen by us: _____

Hobbies and Interests: _____

Previous Dentist: _____ Date of last visit: _____

Emergency Contact: Name: _____ Relationship to you: _____ Phone: _____

Primary Physician: _____ Clinic: _____

SPOUSE'S INFORMATION:

Name: _____ Birth Date: _____

Employer: _____ City: _____

Work phone: _____ Ext:_____ SS #: _____

DENTAL INSURANCE INFORMATION:

Insurance company name: _____

Policy holder's name: _____ Policy holder's birth date: _____

Policy holder's ID/ Social Security #: _____ Group #: _____

Insurance company address: _____ Phone: _____

Do you have a Secondary Insurance? **O** Yes **O** No

If so, which Insurance company is it through? _____

Who is responsible for the balance due on this account (in addition to insurance payment)?

O Myself **O** Spouse **O** Parent **O** Other: _____