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

Date_____

Name: _____(_____)
Last **First** **Middle** **Preferred-name**

M _____ F _____ Birth Date_____ SS# _____

Address_____

_____ _____ _____ _____
City State ZIP Email Address

_____ Single _____ Married _____ Divorced _____ Widowed _____ Separated

Home Phone _____ Work Phone _____Cell Phone _____

When/Where/Best time to reach you?_____

Employer _____ City _____

How long there? _____ Occupation _____

Who may we thank for referring you? _____

Other family members seen by us:_____

Hobbies and Interests: _____

Previous Dentist _____ Last visit date_____

Emergency Contact: #_____

Primary Physician: # _____

Spouse Information

Name _____ Birth Date_____

Employer _____ City _____

Work phone _____ Ext._____ SS# _____

Nearest relative not living with you: Name _____Phone _____

Dental Insurance Information

Primary insurance company name_____

Policy holder name _____ Employer _____

Insurance company address _____

Group # _____ Phone # _____

ID# _____ SS# _____ Date of Birth _____

Secondary dental insurance _____

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

_____ Myself _____ Spouse _____ Parent Other _____