Rogers Family Dentistry

Patient's Name: _____ DOB: _____

Home Address: _____ Zip: _____

Prefer to be called: _____ SSN (required): _____

Home Phone: _____ Work Phone: _____

Cell Phone/Pager: _____ Sex: M F

Employer: _____ Marital Status: S M D W Separated

Spouse: _____ SSN: _____ DOB: _____

Employer: _____ Work Phone: _____
**If we are billing insurance through your spouse, we *must* have their SSN and DOB.

Who can we thank for referring you to our office? _____

In case of emergency, contact: _____ Phone: _____

Primary Dental Insurance Coverage
We do not bill medical insurance. You must have a card or claim form in order for us to bill your dental insurance. If the subscriber is not listed above as patient or spouse, we must have their SSN and DOB.

Subscriber Name: _____ Relation to Patient: _____

Subscriber's Employer: _____ Ins. Company: _____

Ins. Co. Address: _____ Group #: _____

Secondary Dental Insurance Coverage

Subscriber Name: _____ Relation to Patient: _____

Employer Name: _____ Ins. Company: _____

Ins. Co. Address: _____ Group #: _____

Please sign the authorization below:
I direct the insurer to pay Rogers Family Dentistry all benefits due as the result of my claim. Although I may be covered by insurance, I am aware that I am personally responsible for all charges. I acknowledge the receipt of a copy of Rogers Family Dentistry's Financial Policy.

I authorize Rogers Family Dentistry to release all necessary information to my insurance company regarding my diagnosis and treatment. I also authorize Rogers Family Dentistry to discuss and/or release information to any other dentist, physician, or pharmacist involved in my treatment. I acknowledge the receipt of Rogers Family Dentistry's "Notice of Privacy Practices". A photostatic copy of this authorization is as valid as the original.

Signature: _____ **Date:** _____
(of responsible party))