ROOKER
Family Dentistry

Patient Information

Name_____Soc. Sec. # _____
Last, First, Middle Initial

Address _____ ODL # _____

City _____ State _____ Zip _____ Phone _____

Sex: M ☐ F ☐ Birthdate _____ Age _____ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐

Email _____ Employed By _____ Phone _____

Spouse _____ Emergency Contact _____ Phone _____

Whom may we thank for referring you?_____

For Minor Patients

Parent/Guardian _____ Relationship _____

Birthdate _____ Soc. Sec. # _____ Phone _____

Address _____ State _____ Zip _____

Employed By _____Occupation _____ Phone _____

Primary Insurance

Policy Holder/Subscriber _____ Birthdate_____Soc. Sec. # _____

Relationship to Patient _____Insurance Company _____

Phone _____ ID # _____Group # _____

Ins. Co. Address _____State _____ Zip _____

Secondary Insurance

Policy Holder/Subscriber _____ Birthdate_____Soc. Sec. # _____

Relationship to Patient _____Insurance Company _____

Phone _____ ID # _____Group # _____

Ins. Co. Address _____ State _____ Zip _____