SPRAGUE, PACKHAM & PIZZA DENTAL CORPORATION

Rosewood Dental Group

Patient Registration

Please print the following confidential information

Patient Chart Number

For Office Use Only

PATIENT

Last Name _____ First Name _____ Middle Initial _____ Date of Birth ___/___/___ Month Day Year

Address _____ Street # Street City State Zip

Social Security Number [| |] Status ☐ Married ☐ Single ☐ Child ☐ Other _____ Full Name of Spouse / Parent's Name

Gender ☐ Male ☐ Female

Home Phone ( ) _____ - _____ Fax ( ) _____ - _____

Cell Phone ( ) _____ - _____ E-mail: _____

Closest relative not living with you _____ Phone _____

Person to contact in an emergency _____ Phone _____

YOUR WORK

Patient's Employer _____ Patient's Occupation _____

Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____ ext. _____ How Long _____

SPOUSE'S WORK

Spouse's Employer _____ Spouse's Occupation _____

Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____ ext. _____ How Long _____

ADDITIONAL INFORMATION

How long have you lived in this area? _____ years

About how far is it from your house to our practice? _____ miles

How did you hear about this practice?

☐ Advertisement ☐ Professional Referral _____
☐ Yellow Pages
☐ Friend or Relative _____ Phone _____
☐ At w ork (business associate) _____
☐ Insurance related
☐ Other _____

Is any one else in your family a patient here? ☐ Yes ☐ No If yes, who _____

Is there a particular Doctor you wish to see?

☐ ***No Preference***

☐ **Bob Sprague, D.D.S.** ☐ **Ken Anderson, D.D.S.**
☐ **Scott Packham, D.D.S.** ☐ **John Endow, D.D.S. (Periodontist)**
☐ **Matt Pizza, D.M.D.**

Name of previous dentist? _____ Location _____

(OVER)

Account Information

RESPONSIBILITY

Person Responsible for Account _____ Phone # _____

Driver's License # _____ State _____

PRIMARY

Carrier Name _____ Group Plan _____ Group # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Name of Subscriber _____

Social Security # _____ Date of Birth _____

SECONDARY

Carrier Name _____ Group Plan _____ Group # _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Name of Subscriber _____

Social Security # _____ Date of Birth _____

PAYMENT PREFERENCE

Our credit policies have been established to ensure that the best dental services can be provided to you and your family, and to help prevent any misunderstandings.

Our professional services are rendered to the patient, and not to the insurance company. The insurance company is responsible to the patient, and the patient is responsible to the doctor. We will not provide services on the assumption that the charges will be paid for by the insurance company. With or without insurance coverage, you are responsible for full payment of your total bill.

Payment is due and payable as services are rendered.

For your convenience, our office will process and submit insurance claims on your behalf, and we also can assist you with financial arrangements should you wish to make monthly payments.

Please indicate how you wish to handle your account.

- ☐ I will pay cash the day of treatment (eligible for cash discount)
- ☐ I have no insurance, and wish to finance the costs of treatment
- ☐ I have insurance, and will pay cash for my portion on the day of treatment
- ☐ I have insurance, but wish to obtain financing for my portion

I consent to have my insurance benefits assigned directly to this dental office.

Please sign here _____

CONSENT

I, undersigned, hereby state that to the best of my knowledge the information on the front and back sides of this form is accurate and true. **I consent to all necessary dental procedures agreed upon by my dentist and myself.**

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been made. I understand that even though you may assist me with the processing of my insurance claims, I am responsible for the total balance. I further understand that a 1 1/2% finance charge (18% APR) will be added to any balance over 90 days. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs, attorney fees, and court costs as may be required to effect collection of this note.

Patient _____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____