DRY CREEK DENTAL

SHEFFIELD LLOYD, D.D.S.

Parents/Guardians Names:

First Name Middle Last First Name Middle Last

Children/Dependents:

First Name	Middle	Last	Preferred Name	Date of Birth
First Name	Middle	Last	Preferred Name	Date of Birth
First Name	Middle	Last	Preferred Name	Date of Birth
First Name	Middle	Last	Preferred Name	Date of Birth
First Name	Middle	Last	Preferred Name	Date of Birth
First Name	Middle	Last	Preferred Name	Date of Birth

Responsible Party Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ (circle one) Male - Female Marital Status: (circle one) Married - Single - Divorced - Separated - Widowed

Address: _____City, State, Zip: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____Other: _____

Date of Birth: _____ Social Security Number: _____ Drivers License Number: _____

Referred By (Circle One) Phone Book – Insurance Company – Banner - Health Fair – ValPak Mailer - Patient: _____Other: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient (circle one) Self - Spouse – Parent - Child - Other

Address: _____City, State, Zip: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____Other: _____

Insured Social Security Number: _____Insured Date of Birth: _____

Employer Name: _____ Employer Phone Number: _____

Employer Address: _____City, State, Zip: _____

Insurance Company: _____Address: _____

City, State, Zip: _____ Phone Number: _____

Subscriber ID Number: _____ Group Number: _____ Group Name: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Patient (circle one) Self - Spouse – Parent - Child - Other

Address: _____City, State, Zip: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____Other: _____

Insured Social Security Number: _____Insured Date of Birth: _____

Employer Name: _____ Employer Phone Number: _____

Employer Address: _____City, State, Zip: _____

Insurance Company: _____Address: _____

City, State, Zip: _____ Phone Number: _____

Subscriber ID Number: _____ Group Number: _____ Group Name: _____

I agree to be financially responsible for the procedures I choose to have performed. All estimated fees are required to be paid in full at the time of service. If for any reason a patient is not prepared financially at the time of service, the appointment will be rescheduled. In the case of emergencies, the finances will be decided upon on an individual basis. Any balances over 60 days will be charged a finance fee of 1.5% monthly. For those having Insurance coverage, we will bill the Insurance Company as a courtesy to you. However, during treatment, co-payments must be paid at the time of service. Should this account go to collections, all court costs, Attorney fees, and a 50% collection fee will be added. Any appointments that are missed or not cancelled/re-scheduled 48-hours prior to the appointment will be charged a $50.00 fee.

Signed:_____Dated:_____

Witness:_____