DRY CREEK DENTAL

SHEFFIELD LLOYD, D.D.S.

PATIENT REGISTRATION

Patient 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: _____

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

Email Address: _____ Date of Birth: _____ Social Security Number: _____

Drivers License Number: _____

How did you hear about us? Patient: _____Other: _____

Responsible Party (if someone other than the patient)

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: _____

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

Email Address: _____ Date of Birth: _____ Social Security Number: _____

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: _____

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

Please let receptionist know if you have secondary insurance.

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:_____

DRY CREEK DENTAL

DENTAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

Reason for seeking dental care at this time? _____

Date of last dental visit: _____Reason? _____ Date of last dental x-rays: _____

Previous Dentist: _____ City/State: _____

How often do you Brush: _____ times per: _____ (day or week) Floss: _____ times per: _____ (day, week or month)

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

Have you ever had nitrous oxide (laughing gas) during dental treatment? Yes No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please circle any that apply)

Aching or sensitive teeth	Broken fillings	Areas of food traps	Oral surgery (other than wisdom teeth)
Sensitive or bleeding gums	Loose teeth	Difficulty opening wide	Clicking or popping in jaw
Grinding or clenching teeth	Bad breath	Gum infection	Jaw pain or tiredness
Cold sores	Dry mouth	Periodontal treatment	Orthodontic treatment

Other _____

IF YOU COULD CHANGE YOUR SMILE, WHAT WOULD YOU CHANGE? (Please circle any that apply)

Close gaps between teeth	Replace old fillings	Change shape of teeth	Replace missing teeth
Straighten or even front teeth	Whiten teeth	Make teeth a uniform color	Other _____

PLEASE MARK ANY CONCERNS WHICH MAY KEEP YOU FROM HAVING DENTAL TREATMENT: (circle any that apply)

Lack of importance	Fear of pain	Cost of treatment	Missing work time
Unfavorable dental experience	No concerns	Other _____	

MEDICAL HISTORY

Physician's Name: _____ Are you currently under a physician's care? Yes No

If so, for what reason? _____

Please list any drugs, medications, or injections taken in the last three months. Please include dosage, if known and reason_____

ALLERGIES (*please circle any that apply*) Aspirin Codeine Latex Penicillin Sulfa Local Anesthetics Other _____

To indicate you have had any of the following please circle any that may apply:

Artificial Heart Valve	Liver Disease	Glaucoma	Bleeding Problems	Asthma
Heart disease	Kidney disease	Radiation Treatment	Circulatory problems	Cancer
Heart murmur	HIV Infection or AIDS	Sinus trouble	Frequent Headaches	Heart Surgery
Mitral Valve Prolapse	Herpes	Tuberculosis	Chemotherapy	Chemical Dependency
Pacemaker	High Blood Pressure	Diabetes	Psychiatric Treatment	Artificial Joints
Back Problems	Rheumatic/Scarlet Fever	Epilepsy or Seizures	Fainting or Dizzy spells	Hepatitis A, B, C

Stroke Women Only: Are you Pregnant? Y N Due Date: _____ Are you Nursing? Y N Taking oral contraceptives? Y N

Have you ever taken Fen-Phen or Redux? Yes No Have you had any major surgeries in the last five years? Yes No

Have you ever been requested to take antibiotics or other medications before a dental appointment? Yes No

Do you use cigarettes: No Yes: packs per day: _____ Smokeless tobacco: No Yes: Frequency: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in my (or Patient's) medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____DATE: _____

DRY CREEK DENTAL
DR. SHEFFIELD LLOYD

Helpful information regarding your Dental Benefits

NO "INSURANCE" PAYS 100% OF ALL PROCEDURES

Dental insurance was not designed to pay for all dental care. It is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is simply not true. Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. All levels of payment by insurance companies, including usual and customary (UCR), are governed by the premiums paid. **They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; likewise your treatment should not be governed by your insurance contract**.

BENEFITS ARE NOT DETERMINED BY OUR OFFICE

You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the *usual customary or reasonable fee "UCR" used by the company. This can be very misleading and simply is not accurate.*

All of our fees have been accepted by Delta Dental (considered the standard for dental insurance companies), as usual and customary. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

DEDUCTIBLES & CO-PAYMENTS MUST BE CONSIDERED

When estimating dental benefits, deductibles and percentages must be considered. To help illustrate we will use the following example. The fee for service is $150. Assuming that the insurance company allows $150 as its UCR fee, we can figure out what benefits will be paid. First a deductible, paid by you the patient, on average is $50. The deductible comes off of the top of the $150, leaving $100. The plan will then pay 80% of this particular procedure. The insurance company will pay 80% of the $100. Out of the $150 they will pay an estimated $80, leaving a remaining portion of $70, to be paid by you the patient. Of course, if the UCR is less than the $150 or your plan pays only at 50% then the insurance benefits will be significantly less.

Please note that each and every employer has the ability to determine the benefits you receive from your insurance company. As a courtesy to our patients we will do our best to obtain a copy of your estimated benefits. *As you can imagine with so many different benefit plans available it is nearly impossible to get more than an estimate for you. We will do everything in our power to estimate co-pays accurately, but they are just that, an estimate. Please understand that the dental insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility.*

Our Office Policy Regarding Dental Benefits

YOUR *ESTIMATED* CO-PAY IS DUE ON THE DAY OF TREATMENT.
ANY CO-PAY THAT HAS TO BE BILLED TO YOU IS SUBJECT TO A $15 BILLING CHARGE.

If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we collect from you the estimated amount of the treatment. We will file insurance claims electronically so your insurance company will receive each claim within days of the treatment. By law, your insurance company is required to pay each claim within 30 days of receipt. You are responsible for any balance on your account after 30 days, whether insurance paid or not. If you have not paid your balance within 30 days, finance and billing charges will be added to your account each month until paid. We will gladly send you a refund if your insurance pays more than was expected.

Please understand that we file dental insurance claims as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. We also cannot be responsible for any errors in filling your insurance; once again we file claims as a courtesy to you.

Most importantly, please keep us informed of any insurance changes such as policy name, insurance company address, or change of employment. I have read and understand this information on Insurance.

Signed _____ Date _____

DRY CREEK DENTAL
SHEFFIELD LLOYD, D.D.S.

CONSENT TO PROCEED

I authorize Dr. Sheffield Lloyd and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility. This includes arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: _____

Signature:_____ **Date:**_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ **Date:**_____

DRY CREEK DENTAL

SHEFFIELD LLOYD, D.D.S.

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that ultimately he or she is personally responsible for payment of all dental services. However, our office will prepare insurance forms for our patients and assist in making collections from insurance companies. We will credit any such collections received to the patient's account. Any claims not paid by your insurance company after 90 days of submission will be turned over to you the patient and the balance on your account will be due in full immediately. This dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. Therefore, ALL estimated co-pays are due at the time of service, unless prior arrangements have been made with our business manager.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

If you are more than 15 minutes late for any appointment you may be asked to reschedule.
A fee of $50.00 will be charged to each patient missing a reserved appointment without a 48-hour notice.

In consideration for the professional services rendered/to be rendered to me, or at my request, to my minor child or ward, by Dr. Lloyd or his/her assignee; I agree to pay the fees charged for the dental services provided to Dr. Lloyd or his/her assignee at the time the services are rendered, or within five (5) days of billing if credit shall be extended. I further agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 50% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to Dr. Lloyd's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to Dr. Lloyd or his assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care is null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have had a copy of this office's Privacy Policies offered to me. I acknowledge that a copy is always available at the office if such is ever needed. I agree to disclose to the dentist names of any individuals with whom I authorize the Dr. Lloyd to discuss my dental care.

I certify that I have thoroughly read this form and have had any questions or concerns addressed. I hereby agree to abide by the conditions outlined herein.

Signature of Patient, parent or guardian	**Date**	**Relationship to Patient**