Wellspring Family Dental, PA

8737 Asheville Highway
Spartanburg, SC 29316
(864) 578-5812

Patient Information

Patient Name: _____ Date: *03/04/21*
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #:_____ Birth Date: ____

Home phone: _____ Work: _____ Ext:____ Cell: _____

E-Mail:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Do you have or have you ever had any of the following? Please check those that apply:

☐ AIDS or HIV Positive
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnant
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disorder
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

OTHER:
☐ _____
☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

Please provide us with a complete list of your current medications: _____

_____

_____

_____

_____

Referral Information

How did you hear about our office? _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ DOB: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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 performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, by cell or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Wellspring Family Dental, PA

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
You May Refuse to Sign This Acknowledgement
(This form states that we have given you a copy of the HIPPA Privacy Notice)

I understand that, under the Health Insurance and Portability & Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.
Obtain payment from third party payers.
Conduct normal healthcare operations such as assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

_____ _____ Date: ____/_____/____
Signature of patient, parent or guardian Relationship to Patient

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I, _____, authorize Wellspring Family Dental, PA to share my information with the people listed below. The information we may share would possibly include information about: treatment and/or financial arrangements and payment for services. If you are 18 years old or older, but are insured on another family member's insurance, you should list that person's name below.

_____	_____	_____
Name	Relationship to patient	Phone number
_____	_____	_____
Name	Relationship to patient	Phone number
_____	_____	_____
Name	Relationship to patient	Phone number
_____	_____	_____
Name	Relationship to patient	Phone number

Financial Agreement

We realize that every person's finances are unique. The Wellspring team has worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile while respecting your budget.

Payment Options

- We accept cash, checks, debit cards, and all major credit cards.
- **Prompt Self-Pay Discount:** 5% discount on statements $500 or more, if paid in full by cash or check at time of treatment. *(Not applicable with credit card, debit card, CareCredit, or after day of treatment.)*
- **Payment Plan:** For patients who desire a monthly payment plan, we work with CareCredit, a very reputable 3rd party healthcare lender. If you qualify, it works similarly to a credit card. There are no down payments, and the loan can be interest-free if repaid within a certain timeframe.
- **No Insurance? That's OK!** Please ask about out In-House Savings Program or look on our website at www.wellspringfamilydental@gmail.com for more information!

When to Pay: On basic and preventive procedures, payment is due at the time of treatment. If you have insurance, we will ESTIMATE your out-of-pocket expense and collect this portion from you at the time of treatment. In the event of prosthodontic treatment requiring 3rd party lab processing (crowns, bridges, partials, dentures, etc.), we ask that you pay 50% of your estimated amount at the start of treatment and the remaining 50% at completion.

Dental Insurance

We are happy to file the claims necessary to see that you receive the full benefits of your coverage; however, insurance coverage and patient out-of-pocket expenses are ESTIMATED in good faith. We cannot guarantee what your insurance will or will not agree to until the treatment is performed and the claim is processed. The insurance policy is an agreement between you, your employer, and the insurance company only. Please understand that **all patients are directly responsible for all incurred fees, even if insurance denies the claim.** Dental insurance is designed so that it **almost never pays the total bill**. Plans have deductibles, co-payments, yearly maximums, limitations, and some companies use low and outdated fee schedules to determine what they pay. At best, **they pay based on what your employer pays for the insurance, which can vary greatly. Some plans pay 80% of a particular fee, another may pay 15%, and another may pay nothing for the same procedure.** Our fees are carefully and reasonably adjusted based on quality, safety and experience. Please know that we will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance provider has not paid its estimated portion within **60** days, ***you are responsible*** for payment in full at that time, though we will continue to negotiate with your insurance provider for reasonable reimbursement.

Medicare plans will not work with our office. If you have a Medicare supplement or Advantage plan, you may not be eligible for benefit coverage if going out of their network. We do not currently participate in any of those types of plans.

For Patients with Dental Insurance:

I agree to be responsible for all charges for dental services and materials not paid by my insurance plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my insurance claims. I agree to have my insurance payment be made out to and sent directly to Wellspring Family Dental, PA.

I have read and understand the above financial policy for Wellspring Family Dental, PA

Please sign below:

Patient or Guardian: _____ Date: _____