WELLSPRING
PEDIATRIC DENTISTRY

NEW PATIENT FORM

Welcome! We are pleased to welcome you and your child to our practice!
Please take a few minutes to fill out this form. If you have any questions we are glad to help.

Date _____

Patient Information

Patient 1

Name_____ Nickname_____
First Last

Male___ Female___ Birthday____/____/_____

Home Address **(list below)** ☐ **Same as Parent/Guardian 1** ☐ **Same as Parent/Guardian 2** ☐ **Other** _____

Patient 2

Name_____ Nickname_____
First Last

Male___ Female___ Birthday____/____/_____

Home Address **(list below)** ☐ **Same as Parent/Guardian 1** ☐ **Same as Parent/Guardian 2** ☐ **Other** _____

Patient 3

Name_____ Nickname_____
First Last

Male___ Female___ Birthday____/____/_____

Home Address **(list below)** ☐ **Same as Parent/Guardian 1** ☐ **Same as Parent/Guardian 2** ☐ **Other** _____

Parent/Guardian Information

1) Parent/Guardian Name_____ Date of Birth____/____/_____
First Last

Relationship to child ___Mother ___Father ___Stepmother ___Stepfather ___Guardian ___Other

Home Address_____
Street City State Zip

Home Phone:_____ Cell Phone:_____ Email:_____

2) Parent/Guardian Name_____ Date of Birth____/____/_____
First Last

Relationship to child ___Mother ___Father ___Stepmother ___Stepfather ___Guardian ___Other

Home Address_____
(If different from Parent 1) Street City State Zip

Home Phone:_____ Cell Phone:_____ Email:_____

Preferred method of contact? Home Phone Cell Phone Email

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INSURANCE FORM & FINANCIAL POLICY

Thank you for choosing Wellspring Pediatric Dentistry and Dr. Nisha Mehta as your children's dental healthcare provider. Our office is committed to providing your family with the highest quality dental care, so that your children may attain their best smile. Please review our Insurance & Financial Policy. We require that you read and agree to our policies before any treatment. The parent or legal guardian accompanying a minor, who has consented to treatment, is responsible for full payment at time of service.

Children's Names: **1)**_____ **2)**_____
3)_____ **4)**_____

Dental Insurance

Does your child have dental Insurance? ___Yes ___No

Name of Person Insured_____ Relationship to Patient(s)_____

Primary Insured SS#_____ Date of Birth____/____/_____

Insurance Company_____ Employer Name_____

Member ID #_____ Group #_____

Authorization for Release of Health Information

I authorize Wellspring Pediatric Dentistry to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or services rendered or treatment given to my child/children that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union or a similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

Authorization for Submission of Claims and Assignment of Benefits

I authorize Wellspring Pediatric Dentistry to submit claims for payment of services to insurance companies or healthcare service plans that provide coverage for the patient, on my behalf and in my name, and assign insurance benefits otherwise payable to me to Wellspring Pediatric Dentistry, but not to exceed the providers actual charges for covered services.

This authorization shall remain effective for any services rendered to the patient by Wellspring Pediatric Dentistry. I know I have a right to receive a copy of this authorization if requested. I also understand that it is my responsibility to know and understand my benefits, limitations, and exclusions of my individual policy.

Financial Policy

We are obligated to collect the deductible, co-payment and/or co-insurance, which is the estimated amount not covered by your insurance company at time of service. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. In addition, we offer Care Credit, a 3rd party payment program for healthcare offices with deferred interest and extended payment plans for treatment. Please note an additional fee of $35.00 will be applied for returned checks. All account balances over 90 days are subject to a $25.00 late fee.

As a courtesy to you, we will help process your dental insurance claims. Please understand that our office will do our best to provide an accurate insurance estimate. However, this is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Your insurance company and plan benefits determine the amount paid for covered services; non-covered services may be subject to the office fee per Texas Insurance Code Section 843.3115. You are responsible for all balances regardless of the insurance company's arbitrary determination of usual and customary rates. Please contact your insurance company to understand your benefits. If payment is not received or your claim is denied, you will be responsible for the remaining balance. If your insurance payment is greater than the estimated amount, we will promptly mail a refund check within 60 days after the account is reconciled.

We respect your family's financial situation and would be happy to discuss our charges. We also understand that temporary financial situations may arise and affect payment. We encourage you to contact our office promptly for assistance in the management of your account or to discuss any concerns you may have. Thank you for understanding our Financial Policy.

I have read, understand and agree to the above terms and conditions. I understand that responsibility for payment for dental services provided in this office for my children is mine. Payment is due and payable at the time services are rendered, and after insurance claims are finalized.

Name: _____ Relationship to Patient(s):_____
First Last

Billing Address:_____
Street City State Zip

Main Phone:_____ Email:_____

Signature: _____ **Date:** _____

Medical and dental history questions provide us with important information to evaluate, diagnose, and treat your child. Please answer all questions as accurately as possible. If there are any questions you do not understand, we are happy to assist you.

Child's Name_____ Date of Birth____/____/_____
First Last

Medical History

Physician Name_____ Date of Last Medical Exam_____

Is your child up to date with his/her immunizations? Yes No

Is your child presently under medical care? Yes No Reason_____
(Other than routine visits)

Is your child taking any medications? Yes No
If yes, list MEDICATIONS_____

Does your child have allergies or reactions to medications, foods, drugs, anything? Yes No
If yes, ALLERGIC to_____

Has your child ever been hospitalized? Yes No Reason_____

Has your child ever had a surgery under general anesthesia? Yes No Reason_____
Date of Surgery_____

Has your child now or ever had any of the following medical conditions?

Yes	No	Heart Disease	Yes	No	Liver Disease	Yes	No	Epilepsy
Yes	No	Heart Murmur	Yes	No	Kidney Disease	Yes	No	Rheumatic Fever
Yes	No	Bleeding Disorders	Yes	No	Diabetes	Yes	No	ADD/ADHD
Yes	No	Hemophilia	Yes	No	Thyroid Disease	Yes	No	Handicaps/Disabilities
Yes	No	Anemia	Yes	No	HIV/AIDS virus	Yes	No	Hearing Impairment
Yes	No	Sickle Cell	Yes	No	Hepatitis	Yes	No	Vision Impairment
Yes	No	Asthma	Yes	No	Cancer or Tumors	Yes	No	Artificial Bones/Joints
Yes	No	Tuberculosis	Yes	No	Congenital Birth Defects	Yes	No	Allergies to Latex

If you answered yes to any of the above, please explain below
_____
_____

Please list any other medical conditions_____

Dental History

What is the reason for your visit today? _____

Is this your child's first visit to the dentist? Yes No If no, date of last visit_____

Were any x-rays taken at previous dental visits? Yes No

Does your child have any dental pain? Yes No

Characterize your child's dental experiences in the past ___Positive ___Neutral ___Negative

Is there anything else you would like us to know about your child's dental/oral health? _____
_____

I understand the information given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes to my child's medical/dental history.

Signature of Parent/Guardian_____ **Date**_____ **Relationship to Child**_____