



**Heather T. Hudkins, DDS, PC**  
General Dentist

**William V. Brell, Jr., DDS, MSD**  
Pediatric Dentist

### **PAYMENT POLICY**

Please be aware that the parent bringing the child into the office is legally responsible for the payment of all charges. This parent will be responsible to us for fees regardless of any custody agreements or court orders. **We cannot allow this office to become involved in any custody disputes, financial or otherwise.** We operate on a fee-for-service basis and therefore payment is required at each appointment. We do accept Visa, MasterCard, Discover, cash and personal checks. If this account is turned to a collection service, you will be responsible for all collection fees, attorney fees, and court fees.

For our patients with insurance we will file your claims for you as a courtesy: however, we do expect your insurance co-pay at the time of treatment. If we do not receive payment within 45 days from the date of treatment you will be expected to pay for all dental services. All balances over 60 days are subject to a 1.5% service charge.

Any insurance policy is a contract solely between you, as a patient, and the carrier of your insurance. Please make yourself aware of the benefits of your specific policy. If you have any questions concerning fees, please do not hesitate to ask one of our staff members. We will help you in any way we can.

### **APPOINTMENT POLICY**

In consideration of our patients that are waiting to be scheduled it has become necessary to request a \$55 deposit for operatory treatment appointments. A notice of 24 hours must be given for cancellation or rescheduling. If a pattern of broken or cancelled appointment is seen, it may be necessary to place that patient on our inactive list so that we can give our loyal patients our utmost care and attention. If the office is closed when you call please leave a message with our answering service.

Please list patient's name(s) \_\_\_\_\_

Responsible party's name (printed) \_\_\_\_\_

Responsible party's signature \_\_\_\_\_

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*dentistry for children*

Doctors Building, Suite E-10 1531 East Sunshine Street Springfield, Missouri 65804

**P H O N E** 417-883-5866, 1-800-383-5866 **F A X** 417-883-5898



**For Office Use Only**

I verbally reviewed the medical/dental information below with the parent/guardian and patient named herein.

Initials	Date / /	Insurance: Effective Dat / /	<input type="radio"/> Preventive <input type="radio"/> Major <input type="radio"/> Maximum	<input type="radio"/> Deductible Basic <input type="radio"/> Electronic Claims
Does insurance cover sealants? If yes, what do they fall under?			Doctor's Comments	
<input type="radio"/> Yes <input type="radio"/> No				

**1 CHILD'S INFORMATION**

Child's Full Name: Last, First, MI, Nickname		<input type="radio"/> Male <input type="radio"/> Female	Birthday / /	Age	Height	Weight
Child's Home Phone Number: ( )	Child's Home Address: Street, City, State, Zip					
Child's Social Security Number:	Has any member of your family been a patient in this office? If yes, Name					
Child's Siblings: Name	Age	Name	Age	Name	Age	

**2 MOTHER'S INFORMATION**

Mother's Name: Last, First, MI		<input type="radio"/> Stepmother <input type="radio"/> Guardian	Birthday / /
Employer: Company name and Occupation	Social Security #	Drivers License #	
Home Address: Street, City, State, Zip		Home Phone: ( )	
Work Phone: ( )	Ext.	Cell Phone: ( )	Email Address:

**3 FATHER'S INFORMATION**

Father's Name: Last, First, MI		<input type="radio"/> Stepfather <input type="radio"/> Guardian	Birthday / /
Employer: Company name and Occupation	Social Security #	Drivers License #	
Home Address: Street, City, State, Zip		Home Phone: ( )	
Work Phone: ( )	Ext.	Cell Phone: ( )	Email Address:

**4 PERSON RESPONSIBLE FOR ACCOUNT**

Name: Last, First, MI		Relationship to Child	Birthday / /
Employer: Company name and Occupation	Social Security #	Drivers License #	
Billing Address: Street, City, State, Zip		Home Phone: ( )	
Work Phone: ( )	Ext.	Cell Phone: ( )	Email Address:

**5 PRIMARY DENTAL INSURANCE**

Insurance Co. Name:	
Insurance Co. Address: Street, City, State, Zip	
Insurance Company Phone Number: ( )	Group # (plan, local, or policy #)

**Policy Owners Information:**

Name: Last, First	Relation to Patient:
Social Security Number:	Birthday / /
Employer:	

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## CHILD'S DENTAL HISTORY

Is this your child's first visit to the dentist? <input type="radio"/> Yes <input type="radio"/> No	If not, how long since the last visit?	Name of previous dentist:	Name of family dentist:
Were any x-rays taken at previous dental visits? <input type="radio"/> Yes <input type="radio"/> No	Have there been any injuries to the teeth, face or mouth? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain.		
What is the purpose of today's visit?		Any pain or tenderness in jaw/joint? (TMJ/TMD)? If yes, please explain. <input type="radio"/> Yes <input type="radio"/> No	
Has the child ever had a serious or difficult problem associated with previous dental work? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain.		How do you think your child will react to their dental visit?	<input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor
<input type="radio"/> Yes <input type="radio"/> No Is the child's water fluoridated?	<input type="radio"/> Yes <input type="radio"/> No Floss his/her teeth daily?	<input type="radio"/> Yes <input type="radio"/> No Does child brush teeth daily?	
<input type="radio"/> Yes <input type="radio"/> No Is the child taking fluoride supplements?	<input type="radio"/> Yes <input type="radio"/> No Supervised while caring for teeth?	By whom	Times per day
Does Your Child Have Any Of The Following Habits?			
<input type="radio"/> Yes <input type="radio"/> No Lip Sucking/Biting	<input type="radio"/> Yes <input type="radio"/> No Nursing Bottle Habits	<input type="radio"/> Yes <input type="radio"/> No Pacifier	<input type="radio"/> Yes <input type="radio"/> No Mouth Breather
<input type="radio"/> Yes <input type="radio"/> No Nail Biting	<input type="radio"/> Yes <input type="radio"/> No Thumb/Finger Sucking	<input type="radio"/> Yes <input type="radio"/> No Breathing Issues	

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## CHILD'S HEALTH HISTORY

Has The Child Ever Had Any Of The Following Conditions?					
<input type="radio"/> Yes <input type="radio"/> No Abnormal Bleeding	<input type="radio"/> Yes <input type="radio"/> No Hepatitis	<input type="radio"/> Yes <input type="radio"/> No Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No Handicaps/Disabilities	<input type="radio"/> Yes <input type="radio"/> No Cancer	<input type="radio"/> Yes <input type="radio"/> No Hypertension
<input type="radio"/> Yes <input type="radio"/> No Allergies to any drugs	<input type="radio"/> Yes <input type="radio"/> No HIV +/-AIDS	<input type="radio"/> Yes <input type="radio"/> No Blood Disorder	<input type="radio"/> Yes <input type="radio"/> No Hearing Impairment	<input type="radio"/> Yes <input type="radio"/> No Congenital Heart Disease	<input type="radio"/> Yes <input type="radio"/> No Dysrhythmias
<input type="radio"/> Yes <input type="radio"/> No Premature Birth	<input type="radio"/> Yes <input type="radio"/> No Kidney/Liver Conditions	<input type="radio"/> Yes <input type="radio"/> No Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No Any hospital stays	<input type="radio"/> Yes <input type="radio"/> No Convulsions/Epilepsy	<input type="radio"/> Yes <input type="radio"/> No Drug Sensitivities
<input type="radio"/> Yes <input type="radio"/> No Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No Rheumatic/Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No Anemia	<input type="radio"/> Yes <input type="radio"/> No Any Operations	<input type="radio"/> Yes <input type="radio"/> No Pregnancy	<input type="radio"/> Yes <input type="radio"/> No Brain Injury
<input type="radio"/> Yes <input type="radio"/> No Hemophilia	<input type="radio"/> Yes <input type="radio"/> No Allergies to Latex	<input type="radio"/> Yes <input type="radio"/> No Angina	<input type="radio"/> Yes <input type="radio"/> No Asthma	<input type="radio"/> Yes <input type="radio"/> No Seasonal Allergies	
<input type="radio"/> Yes <input type="radio"/> No Respiratory or breathing problems	<input type="radio"/> Yes <input type="radio"/> No Prior Anesthesia complications				

Please discuss any serious medical conditions the child has had:

Please list all the drugs the child is currently taking: (Rx, non-Rx), Dosage, Intervals

Is the child allergic to any food or medicine?

Child's Physician: Address, Phone number

Date of last visit:

Is the child currently under the care of a physician?

 Yes  No If yes, please list what conditions

Child's current physical health:

 Good  Fair  Poor

How did you hear about our office?

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## EMERGENCY CONTACT

Name: Last, First, Relationship to child	Home Phone: ( )	Work Phone: ( )	Cellular Phone: ( )
Address: Street, City, State, Zip			

I certify that my child is covered by \_\_\_\_\_ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my

insurance submissions, whether manual or electronic. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. I hereby authorized direct payment to my dentist for dental benefits otherwise payable to me.

Signature of Parent or Guardian

X

Date

/ /

Relation to Patient



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General Dentist

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Pediatric Dentist

### PERMISSION FOR TREATMENT

Patient Name \_\_\_\_\_

I (being the parent or legal guardian of the above minor patient) hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures Dr. Brell or Dr. Hudkins may deem necessary during treatment.

I understand that Dr. Brell or Dr. Hudkins and such assistants as he may designate to treat the above mentioned patient will use restorative, oral surgery and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Brell or Dr. Hudkins.

I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. I understand that any treatment proposal given to me is simply an estimate based on the information I provide. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above-name patient.

Date \_\_\_\_\_

Signed \_\_\_\_\_

Relationship \_\_\_\_\_

Witness \_\_\_\_\_



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## NOTICE OF PRIVACY PRACTICES

*This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

*The privacy of your health information is important to us.*

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (4/14/03), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.

If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. *(continued on next page)*

dentistry for children

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We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

#### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.37 for each page, \$15.70 per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (*You must make your request in writing*). Your request must specify the

alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

#### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Contact Officer:** Eric Hudkins

**Telephone:** 417-883-5866

**Fax:** 417-883-5898

**E-mail:** [information@smilezonedentist.com](mailto:information@smilezonedentist.com)

**Address:** 1531 E. Sunshine St. Suite E-10,  
Springfield MO, 65804

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002; April 30, 2009).

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*You may refuse to sign this acknowledgement.*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**BELOW FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

\_\_\_ Individual refused to sign.

\_\_\_ Communication barriers prohibited obtaining the acknowledgement.

\_\_\_ An emergency situation prevented us from obtaining acknowledgement.

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