BRADLEY
HUDSON DMD

927 S. Durkin Drive, Suite B • Springfield, IL 62704 • 217-793-1979

# Insurance and Treatment Authorization Agreement

## AUTHORIZATION

I, _____ (Patient, Parent of Patient, Guardian of Patient), hereby authorize Dr. Bradley Hudson to perform such dental services as he deems necessary, to administer anesthetics as he deems necessary and to perform all other dental procedures, which in Judgment of said Dentist may be necessary or advisable for the diagnosis or treatment for the welfare of the patient.

Signature _____ Date _____

## INSURANCE AND FINANCIAL AGREEMENT

Our practice is committed to providing the best treatment to our patients, and we charge what is usual and customary for your individual dental needs. For your convenience, we will submit your Dental Claims to your insurance carrier. However, it will be your Responsibility to follow up with your carrier regarding your claims or predetermination of benefits. You are Responsible for the complete payment of your account, regardless of any Insurer's determination of coverage or reimbursement.

All accounts, regardless of Insurance coverage, are to be paid in Full within 90 days of treatment unless arrangements have been made with the Office Manager. We accept the following:

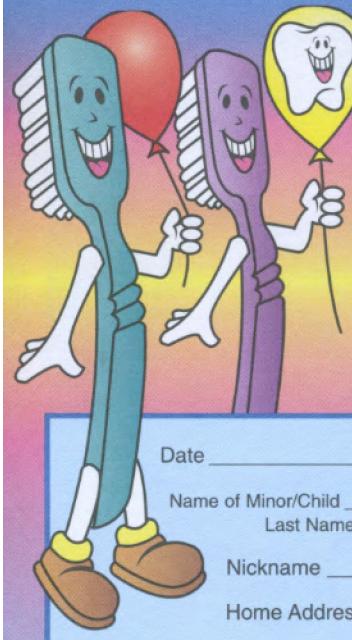
**CASH • CHECK • VISA • MASTERCARD • DISCOVER**

Accounts that have an unpaid balance after 90 days are subject to be sent to our Collection Agency, and a 30 percent Collection Fee will be added to your account.

If Legal Action becomes necessary to obtain payment, you will be responsibile for any cost of and/or Attorney Fees.

In signing this Insurance and Financial Agreement, I attest that I understand and accept these Terms.

Signature _____ Date _____



# Welcome!

**We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.**

## PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

## INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

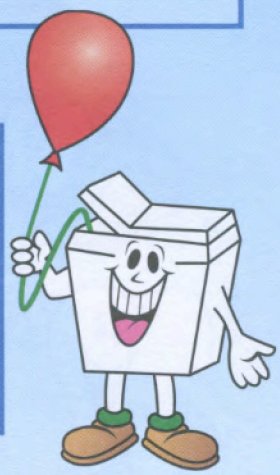
Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

## DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Has child complained about dental problems? | ☐ | ☐ | Is fluoride taken in any form? | ☐ | ☐ |
| Does child brush teeth daily? | ☐ | ☐ | Any injuries to mouth, teeth, head? | ☐ | ☐ |
| Does child use floss every day? | ☐ | ☐ | Any unhappy dental experiences? | ☐ | ☐ |

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐





***Please Complete Both Sides***

# MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

| | YES | NO |
|---|---|---|
| Is Minor/Child under care of physician now? | ☐ | ☐ |
| Receiving any medication or drugs? | ☐ | ☐ |
| Ever been hospitalized? | ☐ | ☐ |
| Ever had surgery? | ☐ | ☐ |
| Is there excessive bleeding when cut? | ☐ | ☐ |

Medications _____

_____

_____

Allergies _____

_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

| | | | | |
|---|---|---|---|---|
| ☐ A.I.D.S./H.I.V. | ☐ Cerebral Palsy | ☐ Epilepsy | ☐ Kidney Disease | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Chicken Pox | ☐ Fainting | ☐ Liver Disease | ☐ Sinus Problems |
| ☐ Asthma | ☐ Convulsions | ☐ Hearing Problems | ☐ Measles | ☐ Thyroid Disease |
| ☐ Bladder Problems | ☐ Diabetes | ☐ Heart Problems | ☐ Mononucleosis | ☐ Tuberculosis |
| ☐ Cancer | ☐ Drug/Alcohol Abuse | ☐ Hepatitis | ☐ Mumps | ☐ Other |

# EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

# AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

**Minor/Child Consent**

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

**Insurance Assignment and Release**

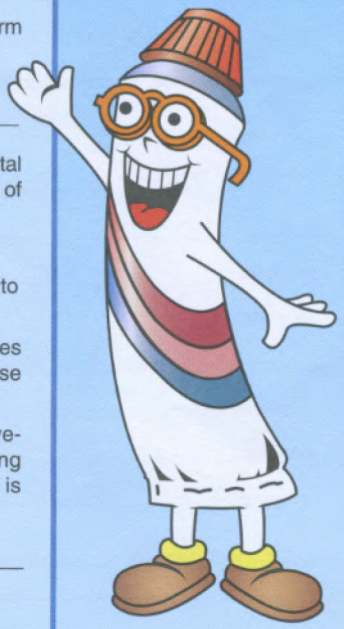
I certify that my dependent(s) is covered by insurance with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient



# UPDATE

**TO BE COMPLETED AT LATER VISIT**

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____