Teddy Bear Dental
Pediatric Dentistry
Dr. Ted I. Kim DDS
3500 Barranca Pkwy, Suite 260
Irvine, CA 92606

Tel: 949-786-1383
Fax: 949-786-1368

Your Child

Name:_____ Nickname:_____
Home Address_____ Birth date:_____Age:_____
_____ Sex:_____
School:_____Grade:_____
Home phone:_____

Referred By: _____

Other children in our office:_____

✔Mother ✔Stepmother ✔Guardian

Name:_____
Birth Date:_____
Soc Sec#:_____
Home Phone:_____
Work Phone:_____
Cell phone:_____
Occupation:_____

Father Stepfather Guardian

Name:_____
Birth date:_____
Soc Sec#:_____
Home phone:_____
Work phone:_____
Cell phone:_____
Occupation:_____

Primary Dental Insurance

Insured's Name:_____
Relationship:_____
BIrth Date:_____
Soc Sec#:_____
Employer:_____
Insurance Company:_____
Address:_____
_____
Phone #:_____
Group #:_____

Secondary Insurance

Insured's Name:_____
Relationship:_____
Birth Date:_____
Soc Sec#:_____
Employer:_____
Insurance Company:_____
Address:_____
_____
Phone#:_____
Group#:_____

Financial Agreement Please provide us wth at least one of the following:

(circle one) VISA#_____ MASTERCARD#_____

Expiration Date(month/year):___/___ Security Code: _____

Name of Cardholder:_____Signature:_____Date:_____

1. I agree to accept responsibility for payment for dental services provided in Teddy Bear Dental(TBD)for my dependent, and I agree to pay all collection cost and attorney fees incurred by my failure to remit for services rendered. I understand that payment is due and payble at the time of service rendered, unless other arrangements have been made with TBD front office. In the event payments are not received by agreed dates, I agree to pay 1.75% per month finance charge(21% per year), and late fees, services charges where applicable. I authorize TBD to charge my credit card for any payments due. I grant my permission to TBD, or its assigns, to contact me at home or my work to discuss matters related to this form and account.
2. I agree to acept responsibility to advise TBD any changes in the information contained on this form.
3. I acknoledge that it is essential that all appointments be kept promptly. In the event that an appointment cannot be kept, Iwill notify TBD at least 2 business days in advance, so that my appointment can be rescheduled, or a missed appointment fee may be charged. I acknoledge that TBD reserves the right to cdiscontinue treatment if, in it's sole opinion, circumstances justify such action.

Authorization I authorize TBD to release any information including the diagnosis and records of any treatment or exam rendered to my child during the period of such dental care to third party and/or other health practitioners, and to reproduce or se at its sole discrection for the purpose of illustration or publication on, but not limited to, our website, in professional journals, or any other type of media. I authorize and request my insurance company to pay directly to the dentist or TBD insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill and/or their coverage for services. I agree to accept respoonsibility for payment of all services provided for my dependent.

Name of Parent or Guardian:_____ Signature:_____Date:_____