Print Form

Tell us about your child

Patient name: _____ Nickname: _____

Date of birth: _____ Age: _____

Gender: ◯ Male ◯ Female Current Weight: _____

Child's favorite pet, toy, hobby or sport: School & Grade (if any):

_____ _____

Home Address: _____ Phone #: _____

_____ Cell #: _____

Who may we thank for referring you? _____

Parent's information

Parent's marital status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Mother's name: _____ DOB: _____ Home #: _____

Address: _____ Cell #: _____

Social Security #: _____ Email: _____

Employer: _____ Work #: _____

Father's name: _____ DOB: _____ Home #: _____

Address: _____ Cell #: _____

Social Security #: _____ Email: _____

Employer: _____ Work #: _____

Who is accompanying the child today? _____

Relationship: _____ Do you have legal custody of this child? **Y / N**

Insurance information

Name of insured: _____ Relation to child: _____

Social Security Number: _____ Date of birth: _____

Employer: _____ Phone #: _____

Insurance Co: _____ Phone #: _____

Insurance Co. Address/P.O. Box:

_____

Group or Policy #: _____ I.D. #: _____

Financial policy

PAYMENT IS DUE AT THE TIME OF SERVICE – The full balance of treatment is due at the time services are rendered. Payment plans are not available from our office. For your convenience we accept cash, debit card, check, Care Credit, Master Card, Visa, and Discover.

ASSIGNMENT OF DENTAL INSURANCE BENEFITS – Our office files insurance benefits as a courtesy. Claims unpaid by your insurance company after 60 days are your responsibility and will be due in full. All deductibles, co-payments and non-covered fees are due at the time of service.

SERVICE CHARGES – A late fee of $5 may be applied to accounts with balances unpaid within 15 days of the statement date. A $30 fee will apply to all returned checks. Our office reserves the right to pursue any other remedy by law.

DELINQUENT ACCOUNTS – Account balances that exceed 60 days may be pursued through third party collections. All resonalbe expenses incurred in the collection process will be the account holder's responsibility.

I affirm that the information I have given is correct to the best of my knowledge. I authorize the dental staff to perform all necessary dental treatment my child may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly Lake Houston Pediatric Dentistry all insurance payments otherwise payable to me. I understand that I am responsible for the full balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all the above mentioned terms.

Signature: _____ Date: _____

LAKE HOUSTON PEDIATRIC DENTISTRY

20035 W. Lake Houston Pkwy, Suite 600, Kingwood TX 77346 • Office: 281 852 3777 Fax: 281 852 3778 • www.drjai.com