**Personal Information**

Name_______________________________________________
Last First MI

Birthday ___________________ SSN _____________________

Address_______________________________________________

Cell #(____)___________________________________________

Hm #(____)_______________________________

**Emergency Contact Information**

Name_____________________________

Cell #(____)______________________

**Insurance Information**

Policy holder name ____________________________________

Policy holder birthday ______________ SSN________________

ID # _____________________ Employer ___________________

Group # ________________ Insurance phone ______________

Policy holder address _________________________________

_____________________________________________________

**Medical Information**

Medical Doctor's name _________________

Have you ever had a heart attack? Y N When? ______________

Have you ever had a stroke? Y N When? _____________

Are you supposed to take blood pressure medicine? Y N

Which ones? __________________________________

Do you have diabetes? Y N

Have you ever had a joint replacement? Y N

When? ___________________

Are you pregnant/nursing? Y N

Do you have any other medical conditions? Y N

Which ones? ___________________ ____________________

___________________ ____________________

Are you allergic to any medicines? Y N

Which ones? ______________________ _____________________

______________________ _____________________

Which pharmacy do you use? _________________________

**We will provide you with good faith estimates based upon the information your carried provides to us about your policy.** Please be aware that insurance carriers never guarantee payment according to the percentages they advertise to you, and they adjust their payments according to the fine details contained within your individual contract. After we submit your claim, your insurance carrier will review it to determine how much it will pay for your dental services. If your carrier pays more than we estimated the overpayment will be used to reconcile any family account balances do. If there are no account balances due, we will issue you a refund after all pending insurance claims have been received.

- I understand that any insurance overpayment will be used to reconcile my family balance before a refund is issued to me.
  Initial _______

**TFD estimates are good for 60 days after they are given.** Please be aware that your insurance policy has a limited amount that your carrier will pay each coverage year for all your dental services. If you were seen or will be seen by another dentist in the current coverage year or if your treatment will require a referral to a specialist's office, your coverage may be exceeded, and your estimated patient portion quoted on your estimate may be incorrect. Please be aware that TFD cannot attain accurate information from your insurance carrier about dental services provided by a previous dentist or specialist. If your carrier denies or downgrades your claim because your annual coverage limit has been exceeded or for any reason, your account with us will be adjusted according to the insurance downgrade and you will be responsible to pay the balance due in full within 30 business days.

- I understand that if my coverage is exceeded or if my claims are denied/downgraded that I will pay the balance in full.
  Initial _______

- I authorize the release of all necessary information to first party payers/health practitioners and request my insurance company to send payment directly to this office. Initial _________
- I certify that I have provided complete and truthful information, knowing that providing incorrect or false information can be dangerous to my health. Initial _________
- I have been offered a copy of the Notice of Privacy Practices and agree to its terms. Initial _________
- I consent to allow my image to be used by TFD for training and marketing purposes Initial _________
- I have been fully informed and all of my questions have been answered. I give my informed consent to be bound by all terms of all policies associated with Jared Cox DDS PA.

  Signature _______________________ Print name _____________ Date ___________