

Child's Name _____
 Last First M
 Birthday _____ SSN _____
 Home Address _____
 Does your child have any medical conditions? Y N
 • Which ones? _____
 Is your child currently taking medicine? Y N
 • Which ones? _____
 Is your child allergic to any medicines? Y N
 • Which ones? _____
 Is your child pregnant/nursing? Y N
 Pediatrician name _____
Legal Guardian's Info: Parent Other _____
 • Name _____
 • Birthday _____
 • SSN _____
 • Cell #(____) _____

- 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 _____

- Policy Holder Name _____
- Policy Holder address _____
- Insurance Company _____
- Employer _____
- Group _____

Policy Holder birthday _____
 Policy Holder SSN _____
 Insurance Phone #: _____
 ID# _____

We will provide you with good faith estimates based upon the information your carrier 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 due. 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 _____