Full Name: _____ ☐ ☐ ☐ (Mr. / Mrs. / Ms.)

Date of birth: _____ Social Security #: _____

Address: _____
(street) (city) (state) (zip code)

Home phone: _____ Mobile phone: _____ Work phone: _____

Employer: _____

Dental Insurance

Primary Insurance

insurance co. name: _____
group #: _____

information on the individual that the insurance is through if other than yourself -
name: _____
relation: _____
SS# / ID#: _____
birthdate: _____
employer: _____

Secondary Insurance

**please note that we do NOT accept secondary insurance assignment*

insurance co. name: _____
group #: _____

information on the individual that the insurance is through if other than yourself-
name: _____
relation: _____
SS# / ID#: _____
birthdate: _____
employer: _____

Financial Agreement

Payment for dental treatment, including insurance co-pays, is due at the time of service.
I agree to be responsible for all charges for dental services not paid by my dental insurance. **I understand that I am electing to have treatment without a written pre-authorization, and thus my dental insurance may pay less than or no part of services today.**
To the extent permitted under applicable law, I authorize release of any information relating to this claim. I also agree to be responsible for any costs of collection that Matthew O. Cox, D.D.S may incur as a result of this account being placed with an outside collection agency. This amount will include a fee of up to **35%** of the amount assigned for collection and also agree to be responsible for any attorney fees or court costs that may be awarded by a court of jurisdiction. NSF checks will be charged $25. I also authorize payment of the dental benefits otherwise payable to me directly to the practice of the treating dentist.

Signature: _____ Date: _____