ACCESS ENDODONTICS

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Home Ph. _____

City _____ State_____ Zip _____

Sex ☐M ☐F Age_____ Birthdate _____ ☐ Single ☐ Married ☐Widowed ☐ Separated ☐ Divorced ☐ Domestic Partner

Patient Employed by _____ Occupation _____

Email _____ Bus. Ph. _____ Cell. Ph. _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Financial Information

Our desire is to provide you with high quality dental care while keeping our fees reasonable and controlling our costs. This page is designed to provide you with helpful information regarding the financial side of dentistry at Access Endodontics.

Payment is always expected at the time you receive dental care. If you have dental insurance, this means your estimated "co-pay" or non-insurance balance, If you do not have insurance, this means your fees for services received.

Payment Options: we accept cash, checks, and the following credit cards: Visa, Master Card, American Express and Discover.

If a check is returned to us by the bank, a $35 "Returned Check" fee will be charged to your account.

Upon approval with Care Credit, we offer our patients a six month, interest-free term loan with no down payment and no-pre-payment penalties.

Patients using Care Credit are not eligible for other courtesies because Access Endodontics is paying finance charges to Care Credit on the patient's behalf.

If you have dental insurance, we are happy to assist you filing claims. It is critical that you provide us with accurate information. If issues with a claim that we cannot resolve then the balance will become yours to pay.

If dental insurance applies: Although this office files insurance claims as a service to our patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS: _____

Signature: _____ Date: _____

Print Name: _____

25 Park Drive, Topsham, ME 04086