Access Endodontics, LLC
Practice Limited to Endodontics

Lance Hashimoto, D.D.S., M.S.
Sheila Stover, D.D.S., M.S., M.P.H.

Mr. Mrs. Ms. Dr.	Last Name	First Name & MI	Birth date	Male Female	Single, Married Divorced Widowed	Previous Name
	Address	City / State / Zip/ Apt #	Social Security No.		E Mail Address	
Home Phone	Cell Phone	Employer	EMERGENCY Contact Name		EMERGENCY Phone	

General Dentist/Referring Office: _____

Payment is Due at Initial Visit as Follows:

Insured Patient: Insurance Benefits are estimated prior to appointment and are not guarenteed, we collect your "estimated" out of pocket.

Uninsured Patients: We would collect in full at the initial visit

☐ **Please check this box if you are a Medicare Beneficiary**

PRIMARY DENTAL INSURANCE			SECONDARY DENTAL INSURANCE		
Policy Holder: (IF NOT PATIENT) **Relationship:** self spouse mother father			**Policy Holder:** **Relationship:** self spouse mother father		
Address *(if different from above)*			**Address** *(if different from above)*		
City / State /Zip			**City / State / Zip**		
Home Phone: ( )	**Cell Phone:** ( )	**Birth date**	**Home Phone:** ( )	**Cell Phone:** ( )	**Birth date**
Social Security Number:			**Social Security Number:**		
EMPLOYER:			**EMPLOYER:**		
PRIMARY DENTAL INSURANCE COMPANY			**SECONDARY DENTAL INSURANCE COMPANY**		
INS. ADDRESS:			**INS. ADDRESS:**		
GROUP OR LOCAL #:			**GROUP OR LOCAL #:**		
SUBSCRIBER / MEMBER ID #			**SUBSCRIBER / MEMBER ID#**		

Your insurance policy is a contract between you and your insurance company. You are responsible for payment to Access Endodontics, LLC, regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at time of service.

I hereby request and authorize my insurance company to pay directly to Access Endodontics LLC., insurance benefits for services rendered. I also understand and agree that **any unpaid balance** not covered by my insurance benefits is my obligation and will be paid by me within the guidelines of Access Endodontics, LLC, policy.

I authorize release of any information pertaining to my claim to the insurance company and direct payment to Access Endodontics.

PATIENT or PARENT/GUARDIAN SIGNATURE _____ DATE: _____