CENTER *for* ENDODONTICS
JOHN P. HOOVER, D.D.S., P.C.

Patient's Name _____

Address _____ Home Phone (  )_____

City/State/ZIP_____ Work Phone (  )_____

Patient's Social Security # _____ Date of Birth _____

Employer _____ Employer's Address _____

Dental Insurance Carrier _____

*Please complete this section if your insurance is through a Spouse, Parent or Guardian:*

Spouse/Guardian Name _____ Date of Birth_____

Spouse/Guardian Social Security # _____

Spouse/Guardian Employer _____ Work Phone (  )_____

Dental Insurance Carrier _____

This account will be paid today by: ☐ Cash ☐ Check ☐ Credit Card

**Financial Arrangements and Dental Insurance**

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover or Care Credit. If you have dental insurance, we must collect your estimated co-payment and/or deductible at the time services are rendered.

As dental care providers, our relationship is with you, the patient, not your insurance company. We will gladly file your insurance claim as a courtesy, but please recognize that all charges not covered by insurance are your responsibility. If we have not received payment from your insurance carrier within 45 days of your visit, payment will be expected from you. Balances not paid within 30 days after your first statement will be subject to a 1 1/2% (one and one-half percent) service charge per month. Attorney's fees and court cost will also be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts.

**Authorized Benefits**

I request that payment of authorized insurance benefits be made to the dental care provider for any services furnished to me or on my behalf. I authorize any holder of dental information about me to release such information to my insurance company and its agents in order to determine benefits payable for related services.

I have read and understand the above financial policies for insurance, unpaid balances and authorized benefits. I understand that the charges are my responsibility.

_____ _____

Patient/Guardian Signature Date

***PLEASE TURN TO BACK OF THIS SHEET TO ANSWER MEDICAL QUESTIONS***