Dentkos Endodontics

16626 Pearl Rd. Strongsville, Ohio 44136
Tel: 440-268-8445 Fax: 440-268-8443

PATIENT INFORMATION

(Dr.,Mr., Mrs., Ms.)First name _____ Middle Initial___Last name _____

Sex:◯ Male ◯ Female Date of Birth _____ Age_____ S.S._____-_____-_____

Married◯ Divorced◯ Legally Separated◯ Widow◯ Single◯

Street_____ City_____ State _____ Zip_____

Home Tel# _____Work Tel#_____Ext._____ Cell # _____

General Dentist _____ Referred by_____Physician _____

Employers Name _____ Emergency contact _____

PRIMARY DENTAL INSURANCE COMPANY

Patient Relation to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Ins. Company Name _____

Address of Ins. Co. _____

_____

Insured's Name _____

Ins. Co. Tel# _____ Group policy #_____

Insurance I.D.# _____

SECONDARY DENTAL INSURANCE COMPANY

Patient Relation to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Ins. Company Name _____

Address of Ins. Co. _____

_____

Insured's Name _____

Ins. Co. Tel# _____Group policy # _____

Insurance I.D. # _____

To the best of my knowledge, all of the above information is correct**.** *I ACCEPT FULL RESPONSIBILITY FOR ALL THE TREATMENT PERFORMED AT THIS OFFICE.* I understand that payment is expected at the time services are rendered. I understand that insurance coverage is a contractual arrangement between my insurance company and myself. I understand that should my account become past due, I will be responsible for all fees, interest charges, late charges and all costs of collection including but not limited to, attorney's fees and court costs. My signature on this form authorizes the release of any information relating to claims filed on my behalf and also authorizes payment send directly to DENTKOS ENDODONTICS, LLC

Signed: Responsible Party _____ Date:_____