Please Complete All of the Following. Please mark N/A if a section does not apply.

Patient Name: ____________________ Birthdate: ___________________

Primary Insurance Information:

Dental Insurance Company Name: ______________________________

State Where Company is Located: ______________________________

Claims/Benefits Phone #:____

Insured's Name: ____

Social Security Number: ______________________________________

ID Number (If different than SS#):______________________________

Birthdate: ____

Address: ____

Phone #:_____________________ Relationship to Patient: ___________

Name of Employer: ____

Name of Dental Group:________________Group #:_________________

Secondary Insurance Information:

Dental Insurance Company Name: ______________________________

State Where Company is Located: ______________________________

Claims/Benefits Phone #:____

Insured's Name: ____

Social Security Number: ______________________________________

ID Number (If different than SS#):______________________________

Birthdate: ____

Address: ____

Phone #:_____________________ Relationship to Patient: ___________

Name of Employer: ____

Name of Dental Group:________________Group #:_________________

THE SIGNATURE BELOW MUST BE THE SIGNATURE OF THE INSURANCE HOLDER. BY SIGNING BELOW, YOU AUTHORIZE YOUR INSURANCE TO PAY BENEFITS TO C.E. KAVANAUGH D.D.S., P.C.

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Signature **Date**