

Ed Kavanaugh, Orthodontist

Please Complete the Following

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 #: _____

AUTHORIZATION TO PAY BENEFITS TO C.E. KAVANAUGH D.D.S., P.C.

Signature

Date

