Ed Kavanaugh
ORTHODONTIST
We Style Smiles

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.

Signature **Date**