



415 Route 34, Suite 108  
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[www.coltsneckorthodontics.com](http://www.coltsneckorthodontics.com)

Welcome to Dr. Cavanagh's office. We sincerely appreciate you choosing our office for your orthodontic needs. In order for us to serve you better, please complete this information form as thoroughly as possible.

## Please tell us about yourself

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Notify in case of emergency: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex: M F

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

## Person Financially Responsible

Person responsible for account: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Do you have dental insurance? Yes No

Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

## Dental Insurance Information

Subscriber's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_

Identification Number of Insured Person: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Group Number: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Do you have additional insurance?

Yes No

If yes, please complete the Additional  
Dental Insurance Information on the  
next page.

**AUTHORIZATION for TREATMENT:** This is to certify that I, the undersigned Patient, consent to all dental procedures agreed to between myself and Colts Neck Orthodontics, L.L.C., and I will assume complete responsibility for all fees associated with those procedures. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

\_\_\_\_\_  
Patient's (Parent's/Guardian's) Signature

\_\_\_\_\_  
Date

Patient's Name: \_\_\_\_\_

## Additional Dental Insurance Information

Subscriber's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Name of Insurance Co: \_\_\_\_\_

Identification Number of Insured Person: \_\_\_\_\_

Plan Name or Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Business Phone: \_\_\_\_\_