

BENKO ★ MCGROGAN
ORTHODONTICS

Patient Insurance Form

Patient Name: _____

Patients Date of Birth: _____

Subscriber Name: _____
(Employee Name)

Subscriber Address: _____

Subscriber Birthdate: _____

Place of Employment: _____

Group Number: _____

Social Security Number: _____
(Employee S.S. Number only)

Insurance Co. Name: _____

Address: _____

Telephone Number: _____

Is patient covered by another Dental Plan?

Yes No

I authorize release of any information relating to this claim.

Signed _____
(Patient, or Parent if minor)

Date: _____

I authorize payments to the below named orthodontists.

Employee Signature _____

Date: _____

Dane D. Benko, D.D.S., M.S.
220 North Main Street
Butler, PA 16001
(724) 287-7767