Dr. Kendall J. Barrowes

Orthodontic Specialist

82 East 900 North

Spanish Fork, UT 84660

(801) 798-1994

Member American Association of Orthodontists

Diplomate American Board of Orthodontics

Date: _____/_____/_____
MONTH DAY YEAR

PATIENT PERSONAL INFORMATION (ADULT)

Patient Name _____ _____
LAST FIRST MI PREFERRED NAME

Please check preferred # for evening confirmation calls:

☐ Home Phone _____

Home Address _____
STREET CITY STATE ZIP CODE

☐ Patient's Cell Phone _____

☐ Spouse's Cell Phone _____

Email _____

Birthday: _____/_____/_____ AGE: _____ Yrs _____ Mos Gender: ◯ Male ◯ Female
MONTH DAY YEAR

Chief reason you are seeking treatment? _____

Family Dentist _____ How did you hear about us? _____

Other family members treated here _____

Please list other children in the family who may need an orthodontic exam:

Name _____ Age _____ Birthdate _____

Name _____ Age _____ Birthdate _____

RESPONSIBLE PARTY INFORMATION

Patient Employed By _____ Position _____ Business Phone _____

Business Address _____
STREET CITY ST ATE ZIP CODE

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated

Spouse Name _____ _____ _____ Birthday _____/_____/_____
LAST FIRST MI MONTH DAY YEAR

Spouse's Address If Different Than Patient's _____
STREET CITY ST ATE ZIP CODE

Employed By _____ Position _____ Business Phone _____

Spouse Business Address _____
STREET CITY ST ATE ZIP CODE

Primary Person Responsible For Account: ◯ Self ◯ Spouse ◯ Other: _____

*Name, Address and Phone #s of others responsible: _____

PLEASE COMPLETE OTHER SIDE

ORTHODONTIC INSURANCE QUESTIONNAIRE

Primary Dental Insurance: ◯ Self ◯ Spouse ◯ Other _____

Name of Insured _____ Birthdate _____

Social Security _____-_____-_____ Subscriber ID No. _____ Group No. _____

Name of Insurance Company:_____ Phone No. (_____) _____

Address _____
STREET OR P.O. BOX CITY STATE ZIP CODE

Name of Employer_____

Address of Employer _____
STREET OR P.O. BOX CITY STATE ZIP CODE

Employer Telephone No. _____

What insurance coverage do you think you have? _____

OFFICE USE ONLY

_____ % up to _____ LTM Date Effective _____
MO DAY YR

COT's Req.? ☐ Yes ☐ No Waiting Period_____ Age Limitation _____

If you have already used any of your allowed orthodontic benefits, please explain _____

_____

Secondary Dental Insurance: ◯ Self ◯ Spouse ◯ Other _____

Name of Insured _____ Birthdate _____

Social Security _____-_____-_____ Subscriber ID No. _____ Group No. _____

Name of Insurance Company:_____ Phone No. (_____) _____

Address _____
STREET OR P.O. BOX CITY STATE ZIP CODE

Name of Employer_____

Address of Employer _____
STREET OR P.O. BOX CITY STATE ZIP CODE

Employer Telephone No. _____

What insurance coverage do you think you have? _____

OFFICE USE ONLY

_____ % up to _____ LTM Date Effective _____
MO DAY YR

COT's Req.? ☐ Yes ☐ No Waiting Period_____ Age Limitation MO DAY YR _____

If you have already used any of your allowed orthodontic benefits, please explain _____

_____

ASSIGNMENT

I hereby authorize Dr. Kendall J. Barrowes to file for benefits with my insurance company(s) covering the treatment of the patient listed on the reverse side and release him all monies received as partial payment for services rendered. I authorize the doctor to deposit insurance checks received on patient's account when made out to the patient. I understand that I am responsible for all charges for these services and agree to pay all charges not paid by the insurance company(s). I understand where appropriate credit bureau reports may be obtained.

Signature _____ Date _____