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 (YOUTH)

Patient Name ______________________________ ________________
LAST FIRST MI PREFERRED NAME

Home Address ______________________________
STREET CITY STATE ZIP CODE

Email ______________________________

Please check preferred # for evening confirmation calls:

☐ Home Phone ________________

☐ Patient's Cell Phone ________________

☐ Father's Cell Phone ________________

☐ Mother's Cell Phone ________________

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

School ______________________________ Grade ________________

Hobbies/Interests ______________________________

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

Father's Name ______________________________ Home Address If different ______________________________
LAST FIRST MI

Employed By ________________ Position ________________ Business Phone ________________

Mother's Name ______________________________ Home Address If different ______________________________
LAST FIRST MI

Employed By ________________ Position ________________ Business Phone ________________

Primary Person Responsible For Account: ☐ Father ☐ Mother ☐ Other*: ________________

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

PLEASE COMPLETE OTHER SIDE

ORTHODONTIC INSURANCE QUESTIONNAIRE

Primary Dental Insurance: ☐ Father ☐ Mother ☐ 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: ☐ Father ☐ Mother ☐ 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 MO DAY YR Limitation ______

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

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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 ________________