Kevin McMinn, DMD, MSD

Orthodontics for Children and Adults

181 First Avenue Ketchum Idaho

400 S. Main St. Ste 202 Hailey Idaho

726-3132

First Name: _____ **MI:**_____ **Last Name:** _____

Birth Date:_____ **Gender:**_____

Social Security #:_____

Physical Address: _____

_____

Mailing Address: _____

_____

E-Mail Address: _____

Telephone: Home:_____ **Cell:** _____

Employer: _____ **Occupation:**_____ **Work Phone:**_____

Dentist Name:_____

Who Referred you to our office? _____

Spouse/Significant Other: _____**Phone:**_____

If patient has orthodontic benefits under their dental plan we will make a photo copy of the insurance card

I hereby request payment of my carrier benefits to be made on my behalf to Kevin McMinn Orthdontics for services they provide to me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of information about me to release to Kevin McMinn Orthodontics, any information to determine these benefits. I understand that Kevin McMinn Orthodontics bills third-party payers as a courtesy, and I am fully responsible for all deductibles, coinsurance and disallowables and will make payment to Kevin McMinn Orthodontics.

_____ _____

(Patient Signature) (Date)