Kevin McMinn, DMD, MSD

Orthodontics for Children and Adults

181 First Avenue Ketchum Idaho
400 S. Main St. Ste.202 Hailey Idaho
(208) 726-3132

Patient First Name: _______________ MI:___ Last:_____________________
Birth Date:___________ Gender:___
Home Address:____
Mailing Address: ______________________________Home Phone:____________

Mother:___________MI:___ Last: _____________ Cell Phone:_______________
Employer:_______________Occupation:__________ Work Phone:_____________

Father:____________ MI:___Last:______________Cell Phone_________________
Employer:_______________ Occupation:_____________ Work Phone:_________

Dentist Name:_____________ Who Referred you to our office? __________________

Name of nearest relative not living with you:_______________________ Phone:____________

***Financial Responsible Party Name:*_____________________*DOB:*_________**

***E-Mail address:*____**

***Responsible Party Social Security #:*_____________________________**

***Mailing Address:*____**

***Home Phone:* _____________ *Cell Phone:*_______________**

***Employer:*___________________ *Work 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.

_____________________________ _________________________________ **Date:__________**

(Patient Signature) **(If minor child, parent/guardian signature)**