



971 Hilltop Dr.
Weatherford, TX 76086

817.599.5084
www.GetBraces.BIZ

Welcome to our office and we look forward to giving you or your family member a great smile. We believe that the patient always comes first and that any healthcare relationship begins with obtaining accurate information. Please be careful to print and answer all questions as completely as possible. If you have any questions, please ask our staff for assistance.

PATIENT INFORMATION (Please print)

PLEASE NOTE: The party completing this information for a minor must be the natural parent or a court appointed legal guardian with proper documentation that may be requested. If serving in another capacity you must have written permission from the natural parent or other proper legal documentation granting such legal authority.

Name: _____
Last First Middle Preferred Nickname

Date of Birth: _____ Age: _____ Sex: _____ Social Security Number: _____

Address: _____
Street City State Zip Area Code + Phone

How did you find out about our office? (Circle all that apply)

- General Dentist
- Internet
- Patient – Relative
- Physician
- Advertisement
- Insurance Company
- Yellow Pages
- Patient – Friend
- Other: _____

Who may we thank for referring you to our office? _____

Please indicate First and Second (circle appropriate number 1 or 2) preferred method of contact for scheduling and confirming appointments.

Home: _____ 1 2 Work: _____ 1 2 Cell: _____ 1 2

Preferred e-mail for office communication, e.g. appointments: _____

******* WHO SHOULD WE CONTACT IN CASE OF EMERGENCY IF UNABLE TO CONTACT A PARENT? *******

Name of NON – PARENT Relative Relationship Area Code + Phone

Name of NON – PARENT Relative Relationship Area Code + Phone

INSURANCE INFORMATION:

Name of Policy Holder: _____
Last First Middle

Name of Employer: _____

Address: _____
Street City State Zip

Name of Insurance Company: _____
Area Code + Phone

Address: _____
Street City State Zip

Group Number: _____ Insured Social Security Number: _____

Insured Date of Birth: _____ Insured Relationship to Patient: _____

