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: _____
Note: The biological sex is extremely important in determining skeletal growth patterns, development, and physical maturity.

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.

Cell: _____1 2 Work: _____ 1 2 Home:_____ 1 2

_____ Initial here if you would like for us to contact you by text message. Cell # if different from above _____

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

**********

Please indicate any types of treatment that you might know about and/or already may be interested in:

_____ Not sure at this time.

_____ Comprehensive Treatment with Traditional Braces: _____ metal _____clear brackets

_____ Treatment with clear aligners, e.g., Clear Correct or Invisalign

_____ Hybrid treatment – start with traditional braces and finish with clear aligners

_____ Short Term Orthodontics:
This form of treatment with braces is short and limited in focus with an average of 6-10 months in treatment time. This treatment **does not address all the orthodontic issues that you may have** and is only offered as a possible option for those patients who are interested in a very short treatment with straight teeth, but not necessarily an optimal bite.

**** PLEASE TURN OVER AND COMPLETE THE OTHER SIDE ****

**RESPONSIBLE PARTY INFORMATION (all applicable blanks must be completed)**

PLEASE NOTE: The party requesting treatment will be known as the "responsible party" or "guarantor" and will be responsible for all fees and charges for services rendered unless other arrangements are made in writing prior to the start of treatment. The party seeking treatment 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. Please attach respective documents.***

Please initial to indicate that you understand the above information: _____

Relationship of Responsible Party/Guarantor to Patient: (circle one)

Self Father Mother Legal Guardian Grandparent Step-Parent Other: _____

Name: _____
Last First Middle

Address: _____
Street City State Zip Area Code+ Phone

Employer: _____
Company Name Street Address

_____
City State Zip Area Code + Phone

Date of Birth: _____ SSN: _____ DL Number: _____

**SPOUSE INFORMATION**: (if applicable)

Relationship to Patient: (circle one)

Self Father Mother Legal Guardian Grandparent Step-Parent Other: _____

Name: _____
Last First Middle

Address: _____
Street City State Zip Area Code+ Phone

Employer: _____
Company Name Street Address

_____
City State Zip Area Code + Phone

Date of Birth: _____ SSN: _____ DL Number: _____

**********

Responsible Party Signature: _____ Date: _____

Returned checks will be electronically collected by a third party for face value plus a minimum $30.00 processing fee and applicable taxes.

*Thank you for taking the time to accurately complete this form and returning it to the front desk.*