WHITE PLAINS ORTHODONTICS™

Adult New Patient Registration Form Date:_____

PATIENT

Last Name:_____ First Name: _____ Middle Initial____

Circle one: Mr. / Mrs. / Ms. / Dr. **Marital Status**: _____ **Sex**: _M _F **Birth Date**: _____ **Age**:_____

Home Address: _____ Apt#: _____

City,State,&Zip Code: _____ Home Phone: _____

For Appointment Reminders:

Cell Phone #:_____ Email Address:_____

Employer:_____ Work #:_____

Occupation:_____

Dentist Name:_____ **Office Phone #**_____

Dental Insurance: **Please Give Your Insurance Card to Our Receptionist

Name of Dental Insurance Co:_____ ID#:_____

Policy Holder's Name: _____ DOB: ____ SS#:_____

Referred by (check) : __Dentist __Insurance __Internet __Friend/Patient (Who:_____)

Allergic to (circle) : Latex Yes/No Nickel (metal) Yes/No

Medical Conditions?_____

Signature: _____