WHITE PLAINS ORTHODONTICS™

New Patient (under 18) Registration Form Date: _____

PATIENT

Last Name:_____ First Name: _____ Middle Initial____

Birth Date: _____ Age:____ Sex: __Male __Female **Prefers to be called**:_____

Home Address: _____ Apt#: _____

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

School _____Grade_____

For Appointment Reminders:

Cell Phone #:_____ Email Address:_____

PARENT/GUARDIAN

Custodial Parent(s) Name(s):_____

(check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Other _____

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

Father's Name:_____ Cell # : _____

Mother's Name:_____ Cell #:_____

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: _____