*Diplomate American Board of Pediatric Dentistry

Pediatric Dentistry
Carlos A. Bertot, D.M.D.*
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Pediatric Dentistry of Central Florida
BERTOT • MANSOUR

Orthodontics
John R. Smith, D.D.S., M.S.D.

PATIENT INFORMATION

Date: _____ ❑ Male ❑ Female

Child's Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE) Nickname: _____

Age: _____ Height: _____ Weight: _____ Date of Birth: _____ SSN#: _____

Name of Brothers and Sisters: _____ Has/Have your child/children been under our care before? ____

Address: _____ (STREET) _____ (CITY) _____ (ZIP CODE) Phone: _____

Mother's Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE) Date of Birth: _____

Address: _____ (IF DIFFERENT THAN PATIENT'S) SSN#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____ Driver's License No./State: _____

Employer's Name: _____ Occupation: _____

Employer's Address: _____ (STREET) _____ (CITY) _____ (ZIP CODE)

Father's Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE) Date of Birth: _____

Address: _____ (IF DIFFERENT THAN PATIENT'S) SSN#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

email: _____ Driver's License No./State: _____

Employer's Name: _____ Occupation: _____

Employer's Address: _____ (STREET) _____ (CITY) _____ (ZIP CODE)

If parents are not living together, who has legal custody? _____

Address: _____ (IF DIFFERENT THAN PATIENT'S)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

In case of emergency notify (Other than parents): _____

Relationship to Patient: _____

Address: _____ (IF DIFFERENT THAN PATIENT'S)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom may we thank for referring you? _____