INTRODUCTORY INFORMATION

PLEASE PRINT EACH ANSWER CLEARLY

Child's Name: ______________________________ **Nickname:** ____________ **Gender:** ☐ **M** ☐ **F**
LAST FIRST MIDDLE

Residence Address: ______________________________ **Date of Birth:** __________ **Age:** ______
STREET ADDRESS CITY STATE ZIP

Child Resides with: ______________________________ **Relationship to Child:** ____________________

Preferred Contact # (   ) ____________________ ☐ **CELL** ☐ **HOME** ☐ **WORK**

By providing your cell phone number, you consent to being contacted at that number by our practice and our representatives regarding treatment and your account. **Initials** ________

Names of Siblings: ________, ______ / ________, ______ / ________, ______ / ________, ______
NAME AGE NAME AGE NAME AGE NAME AGE

Are any of them patients of our practice? ☐ **YES** ☐ **NO** **(If so, please circle siblings name above)**

Father's/Legal Guardian's Name: ______________________________ **Date of Birth:** __________

Residence Address: ____
(If different from child) STREET ADDRESS CITY ZIP

Home: (   ) ______________ **Mobile: (   )** ______________ **Drivers Lic.#** __________

E-mail Address: ______________________________

Employed by: ______________________________ **Position:** ____________________

Social Security# ______-______-______ (required, if you'd like us to bill your insurance company)

Dental Insurance Carrier: ______________________________ **Group #** ____________________

Address: ______________________________ **Phone: (   )** ______________

Mother's/Legal Guardian's Name: ______________________________ **Date of Birth:** __________

Residence Address: ____
(If different from child) STREET ADDRESS CITY ZIP

Home: (   ) ______________ **Mobile: (   )** ______________ **Drivers Lic.#** __________

E-mail Address: ______________________________

Employed by: ______________________________ **Position:** ____________________

Social Security# ______-______-______ (required, if you'd like us to bill your insurance company)

Dental Insurance Carrier: ______________________________ **Group #** ____________________

Address: ______________________________ **Phone: (   )** ______________

Whom may we thank for referring your child to our practice? ______________________________
NAME CITY RELATIONSHIP

Whom may we call in case of an emergency? ______________________________
NAME RELATIONSHIP PHONE #

Pediatrician: ______________________________ **Phone: (   )** ______________
NAME

Specialist: ______________________________ **Phone: (   )** ______________
NAME TYPE OF SPECIALTY

Note: If your child sees more than one specialist, please continue list on the back)

Pediatric Dental Specialists
Santos Cortez, D.D.S., Inc. – Ana M. Planells, D.D.S. – Estela Sanchez, D.D.S.
3320 Los Coyotes Diagonal - Suite 200 - Long Beach, CA 90808 – (562) 377-1375 – Fax (562) 377-1343
www.lbpds.net