BRENT J. PORTER, D.D.S., M.S.

A PROFESSIONAL DENTAL CORPORATION

SANTA CRUZ CHILDREN'S DENTISTRY

550 Water Street, Building D, Suite 1 • Santa Cruz, CA 95060 • (831) 459-9802

WELCOME TO OUR OFFICE! Please complete the following information so that we may become better acquainted.

PATIENT INFORMATION

Name (first, middle, last) _____ Birthdate_____ Sex (M/F) _____

School _____ Grade _____ Interests _____

Other children or dependents:

Name _____ Birthdate_____ Sex (M/F) _____

School _____ Grade _____ Interests _____

Name _____ Birthdate_____ Sex (M/F) _____

School _____ Grade _____ Interests _____

FAMILY INFORMATION

Who is financially responsible for this account? ☐Mother ☐Father ☐Guardian ☐Self

Does the family live together? ☐ YES ☐ NO

PARENT ☐Mother ☐Father ☐Guardian ☐Self

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (cell) _____ (work) _____ Email _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

PARENT ☐Mother ☐Father ☐Guardian ☐Self

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (cell) _____ (work) _____ Email _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Which phone number may we call to confirm appointments? _____

EMERGENCY INFORMATION (Person to contact outside of the immediate family in case of an emergency)

Name _____ Phone _____ Relation _____

Address _____ City _____ State _____ Zip _____

TREATMENT INFORMATION

Purpose of visit (Chief Concern) _____

Is this your child's first visit to our office? ☐ YES ☐ NO Is this your child's first visit to a dentist? ☐ YES ☐ NO

If NO, my child was last seen by? _____ Date of last dental exam? _____

Is any other family member a patient of this office? ☐ YES ☐ NO

If yes, name _____ Relationship _____

Our office includes Orthodontics. Do you want Dr. Porter to follow your child's jaw growth and development? ☐ YES ☐ NO

Whom may we thank for referring you to our office? _____

INSURANCE INFORMATION (Do you have dental insurance? ☐ YES ☐ NO)

Please provide your INSURANCE VERIFICATION CARD so that we can make a copy for your file.

PRIMARY INSURANCE HOLDER ☐Mother ☐Father ☐Guardian ☐Self

Name of Insured _____ Company _____

Dental Insurance Co. _____ Group# _____

SECONDARY INSURANCE HOLDER ☐Mother ☐Father ☐Guardian ☐Self

Name of Insured _____ Company _____

Dental Insurance Co. _____ Group# _____

FINANCIAL POLICY (The following is a summary of our financial policy that will apply to you and all of your dependents)

ALL PAYMENTS AND COPAYMENTS ARE EXPECTED AT THE TIME OF SERVICE. You will receive a billing statement if a balance is due. Payment in full is expected within 60 days of treatment, after which a monthly service charge of 1.5% will be due on your outstanding balance. If payment arrangements are not made and if account is not resolved, your account may be turned over to a Collection and Credit Reporting Agency. You are responsible for any additional fees rendered such as, but not limited to, collection fees, interest and legal fees incurred in collection of your delinquent account. Note: There is a service charge for all returned checks.

INSURANCE

Our office bills participating insurance companies as a *courtesy* to you. You are expected to pay your deductible and copayments at the time of service. It is your responsibility to keep track of your benefits such as eligibility requirements and maximums. Your dental insurance benefits will be assigned to be paid directly to Brent J. Porter D.D.S., M.S., A P.D.C, whenever possible. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are financially responsible for all costs of dental treatment, regardless of insurance coverage. It is your responsibility to contact your insurance company in the event of delayed payment. All recommended treatment is determined to be necessary for the oral health of your child. Failure of your insurance company to pay does not indicate the treatment can wait nor waive any of our fees.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Our office reserves the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Financial Policy for the office of Brent J. Porter D.D.S., M.S., A P.D.C.

Signature of Parent ☐Mother ☐ Father ☐Guardian ☐Self : _____

Printed Name: _____ Date: _____