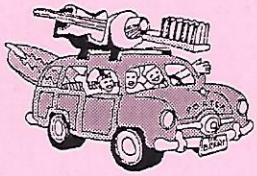

BRENT J. PORTER D.D.S., M.S.

SANTA CRUZ CHILDREN'S DENTISTRY
550 Water Street, Building D, Suite 1 • Santa Cruz, CA 95060 • (831) 459-9802

WELCOME TO OUR OFFICE! SO THAT WE MAY BECOME BETTER ACQUAINTED, PLEASE COMPLETE THE FOLLOWING INFORMATION:

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 (Does the family live together? ❑ yes ❑ no)

FATHER (or male guardian)

Name _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work) _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

MOTHER (or female guardian)

Name _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work) _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Which phone number may we call to confirm appointments? _____

INSURANCE INFORMATION (Do you have dental insurance? ❑ yes ❑ no)

Who is responsible for this account? ❑ Father (or male guardian) ❑ Mother (or female guardian)

FATHER (Please provide INSURANCE VERIFICATION CARD if available)

Name of Insured _____ Deductible $_____

Dental Insurance Co. _____ Group#_____

Company _____ Date Employed _____

S.S.# _____ CA Drivers Lic.# _____

MOTHER (Please provide INSURANCE VERIFICATION CARD if available)

Name of Insured _____ Deductible $_____

Dental Insurance Co. _____ Group#_____

Company _____ Date Employed _____

S.S.# _____ CA Drivers Lic.# _____

TREATMENT INFORMATION

Purpose of visit _____

Is this your first visit to our office? ❑ yes ❑ no

Is any other family member a patient of our office? ❑ yes ❑ no

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

Date of last dental exam _____

If yes, name _____ Relation _____

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

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

AUTHORIZATION

I hereby authorize direct payment to Brent J. Porter D.D.S., M.S. of dental insurance benefits otherwise payable to me, but not to exceed his actual charges for the covered services. I give consent to the Doctor to obtain a credit report pursuant on treatment. I further understand that I am financially responsible for all costs of dental treatment, regardless of insurance coverage. NOTE: Payment in full is expected within 60 days of treatment, after which a monthly service charge of 1.5% will be due on my outstanding account. It is my responsibility to contact my insurance company in the event of delayed payment. I will be responsible for any costs incurred in collection of my delinquent account.

X _____ Date _____

❑ FATHER (or male guardian)

X _____

❑ MOTHER (or female guardian)