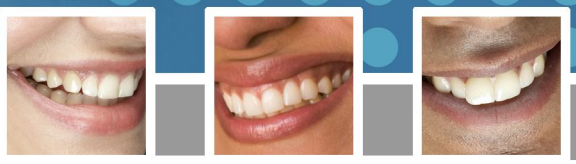
Vivid Smile Dental
27421 Tourney Road, Suite 270
Valencia, CA 91355

(661)799-7912



Welcome to our Practice

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

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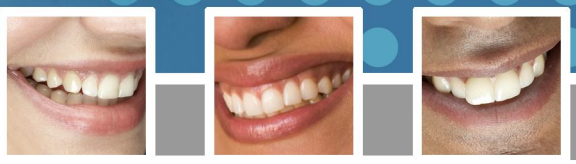

In an emergency who should be notified? Please enter Name and Phone number below:

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or you are the parent/guardian of the patient

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: Last | First | MI | Preferred Name

Title: (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: SS #. Driver's License #:

Email Address: Best time to call:

Phone: Home | Work | Ext | Mobile | Fax | Other

Address:

City | State | Zip Code

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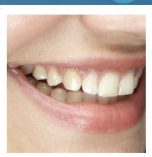
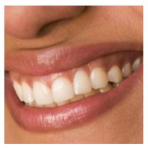
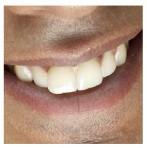

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ _____ _____

City State Zip Code

Insurance Company Phone Number:

_____

Insurance Authorization:

☐ By checking this box,

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

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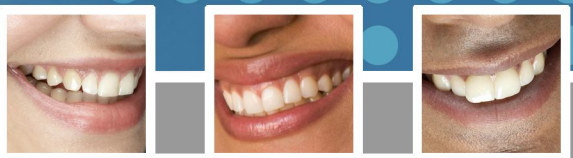

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name and Phone Number:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

Is there anything about the appearance of your smile that you would like to change?

Check all that apply:

☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Had/have braces, orthodontic treatment
☐ You experience dry mouth
☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
☐ Food gets trapped between any teeth
☐ Have you ever whitened or bleached you teeth
☐ Have you experienced popping and/or clicking of your jaw joint

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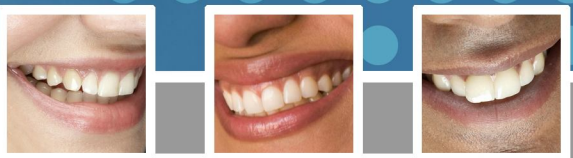

- [ ] You have difficulty chewing
- [ ] You clench or grind your teeth
- [ ] You wear or have worn a bite appliance
- [ ] Gums bleed when brushing or flossing
- [ ] Treated for gum disease or were told you have lost bone around your teeth
- [ ] Noticed an unpleasant taste or odor in your mouth
- [ ] Experienced gum recession
- [ ] Had any teeth become loose on their own (without injury)
- [ ] Experienced a burning sensation in your mouth
- [ ] You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

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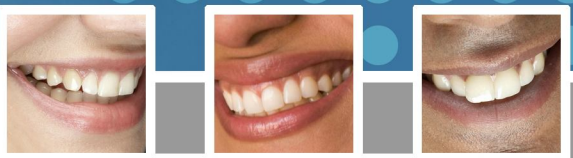


FINANCIAL POLICY

Thank you for choosing Vivid Smile Dental as your dental health care provider. Vivid Smile Dental is committed to your treatment being successful. Please understand that payment of your account is considered a part of your treatment. It is important that your account be handled properly in order to keep charges as low as possible. Your cooperation in this is appreciated. The following is a statement of Vivid Smile Dental's Financial Policy which we require that you read and sign prior to any treatment.

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE
VIVID SMILE DENTAL ACCEPTS CASH, CHECKS, OR CREDIT CARD
VIVID SMILE DENTAL OFFERS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL

It is the patient's responsibility to provide Vivid Smile Dental with up to date insurance information at the time of each visit. When information is given, Vivid Smile Dental may accept assignment of benefits; however, we do require that you pay any co-payment, deductible, and/or additional fees. This payment is required at the time of service unless prior arrangements have been made.

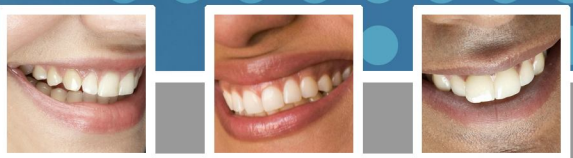
All charges are your responsibility. As a courtesy to you, we will submit claims to your insurance company and may accept assignment of benefits. If, however, your insurance company reduces the amount of, or denies the claim for any reason, the balance of the claim will be your responsibility.

Your insurance policy is a contract between you and your insurance company. Vivid Smile Dental is not a party to that contract.

Vivid Smile Dental may accept assignment of your insurance benefits but Vivid Smile Dental requires that you select an option for paying any remaining balance not covered by your insurance. Your options would include full payment with cash, check, credit card, or a pre-approved extended payment plan. If your insurance company has not paid your account in full within 60 days, the balance will be paid by the option you selected.
Please be aware that some services may not be covered by your insurance plan. This means that you are responsible for the bill.

Regarding insurance plans where we are a participating provider, all co-pays are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, you are responsible for full payment.

Assignment of Benefits
I request payment of insurance benefits to Vivid Smile Dental. I understand that I am financially responsible for all charges not covered by insurance. I acknowledge responsibility to provide Vivid Smile Dental with current patient



information as well as current insurance information. I hereby authorize the release of any information necessary to process all claims.

Usual and Customary Rates

Vivid Smile Dental is committed to providing the best treatment for out patients and our charges are based on cost or what are usual and customary charges in the area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Collection Efforts and Fees

If a balance exists on your account past 90 days from the date of service, Vivid Smile Dental may transfer your account to a collection agency. This will be done at Vivid Smile Dental's option and any costs associated with the collection service will be added to your account.

Adult Patients

Adult patients are responsible for full payment at the time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment plan, or payment by cash, check, or credit card at the time of service has been received, in addition to required consent forms.

Missed Appointments

After your second missed appointment in any twelve month period, Vivid Smile Dental reserves the right to charge a $25 Missed Appointment Fee. This fee is not normally covered by insurance and would be your responsibility. In order to avoid this charge any necessary cancellations must be made at least 24 hours in advance. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Financial Policy.

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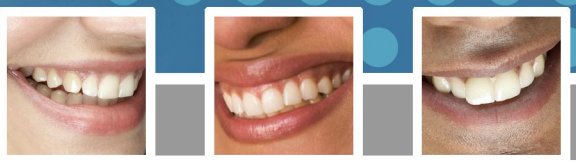

NOTICE OF PRIVACY PRACTICES AND DENTAL MATERIALS FACT SHEET ACKNOWLEDGEMENT

* ☐ By checking this box, I acknowledge that I have received the Notice of Privacy Practices and Dental Materials Fact Sheet and I have been provided an opportunity to review it.

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

* ☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

Response Date: _____