PLEASANT VALLEY

Welcome to Pleasant Valley Cosmetic & Laser Dental PLLC

Our vision is to provide Gentle care and natural beauty

Patient Legal Name _____ Date of Birth _____

Employer _____ SSN _____

□ Male □ Female □ Single □ Married

Cell Phone _____ Work Phone _____

Address _____

City _____ State _____ Zip Code _____

Email _____ Who referred you? _____

Emergency Contact Name _____ Phone Number _____

DENTAL HISTORY

What is most important to you about the way your teeth look, feel, and function?

_____

Would you like to discuss Teeth whitening or teeth straightening options ? □ Yes □ No

Have you ever been told you have Periodontal Disease? □ Yes □ No

HEALTH HISTORY

Women: Are you Pregnant? □ Yes □ No

Do you smoke or use tobacco in any form? □Yes □ No

Please list any medications/supplements you are taking:

_____

_____

When was your last routine medical exam? _____

Physician Name: _____

Please list any serious medical conditions, surgeries, and/or hospitalizations that you have had:

_____

Y	N		Y	N		Y	N		Y	N	
□	□	A.I.D.S / H.I.V	□	□	Diabetes: I II (circle)	□	□	Heart Failure	□	□	Mental Disability
□	□	Anxiety	□	□	Drug/Alcohol Abuse	□	□	Heart Murmur	□	□	Osteoporosis
□	□	Angina Pectoris	□	□	Emphysema/Asthma	□	□	Heart Pacemaker	□	□	Rheumatic Fever
□	□	Arthritis/Rheumatism	□	□	Epilepsy/Seizures	□	□	Heart Surgery	□	□	Shingles
□	□	Artificial Heart Valve	□	□	Fainting/Dizzy Spells	□	□	Hemophilia/Bleed Easily	□	□	Sickle Cell Disease
□	□	Artificial Joints	□	□	Fever Blisters/Cold Sores	□	□	Hepatitis A B C (circle)	□	□	Thyroid Disease
□	□	Anemia	□	□	Frequent Headaches	□	□	High Blood Pressure	□	□	Tuberculosis (TB)
□	□	Chemotherapy/Radiation	□	□	Glaucoma	□	□	Low Blood Pressure	□	□	Ulcers
□	□	Congenital Heart Defect	□	□	Hay Fever/Sinus Trouble	□	□	Kidney Failure/Dysfunction	□	□	STD
□	□	Cosmetic Surgery	□	□	Heart Disease/Attack/Stroke.	□	□	Liver Disease/Jaundice	□	□	Other: _____

Have you ever been told that you need to be premeditated before dental treatment? □ Yes □ No

DO YOU HAVE ALLERGIES TO ANY OTHER MEDICATIONS OR SUBSTANCES YES NO

Y	N		Y	N	
□	□	Antibiotics	□	□	Aspirin
□	□	Codeine	□	□	Latex
□	□	Metals/Jewelry	□	□	Local/Dental Anesthetic

_____

_____

INSURANCE

Primary Insurance _____Policy Holder Name_____ Employer_____Group#_____

Secondary Insurance _____Policy Holder Name_____ Employer_____Group#_____

Primary insurance Policy holder date of birth _____Secondary insurance policy holder date of birth_____

PRIVACY POLICY

I acknowledge that I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care information that might occur in my treatment, payment of services, or in the performance of the office's health care operations.

Pleasant Valley Dental reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective.

I authorize Pleasant Valley Dental to share my information with the individual(s) listed below:

Name _____ Relationship _____

FINANCIAL GUIDELINES

As a courtesy, our team will gladly submit insurance claims on your behalf. We ask that you provide us with the most current dental insurance information and update us as often as changes occur. In addition, we ask that you review your plan and understand the details of coverage including plan limitations, frequencies, waiting periods and maximums. Please also inform us if you have used benefits at another dental office within your plan year. We are happy to provide insurance and patient portion estimates to you. It is your responsibility to contact your insurance company if no payment has been made on a claim after 30 days from the date of service**. Regardless of insurance payment or non-payment, any balance incurred will ultimately be your responsibility.** We have a variety of payment options including Cash, Check, All Major Credit Cards, and Care Credit.

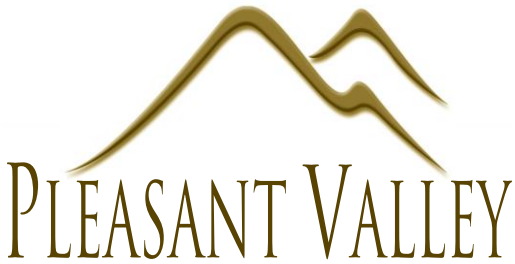
By signing this form, I acknowledge that I have read and agree to the above information. I understand that I am financially responsible for payment of any treatment provided, regardless of insurance payment or non-payment.

I agree to keep my account balance in good standing by closing all balances greater than 45 days past any and all dates of service.

I authorize Pleasant Valley Dental to provide treatment based on my oral health care needs. I agree to communicate any changes to my medical condition(s) at each visit. I understand that I will be informed of any treatment needed and agree to services, regardless of insurance.

Patient Signature _____ Date_____

Witness Signature _____ Date_____



THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGALDUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect Feb 1st, 2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing you treatment.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25.00. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S.
Department of Health and Human Services upon request.

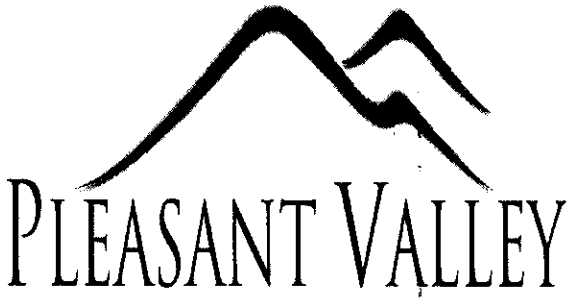
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr Benjamin Christensen

Address: 5742 S. Adams Parkway
Ogden, Utah 84405

Telephone: 801-621-3383

Email: pvclddentistry@gmail.com



Appointment Commitment

We appreciate you choosing us to serve your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time. If circumstances occur and it's necessary for you to change your scheduled appointment, we request a 2-business day notice. Ano call/no show is not acceptable. Please be courteous and call us to discuss the best times for scheduling your appointments.

I acknowledge that I have read and understand this. Please initial here_____

About Your Dental Insurance

We understand how important insurance benefits are to you. Please be informed that dental insurance is a contract between you and your insurance company, as a courtesy we will assist you with filing your insurance claim(s). Your Dentist is providing the highest quality of care for you and your family regardless of insurance frequencies, limitations, and/or restrictions. Please be aware that your insurance has a yearly maximum and anything over that will be your responsibility. If dental services have been provided for you by another provider within your benefit year, those fees will count toward your maximum as well. If you have two insurance policies, please be aware, not all policies will cover remaining portions after your primary Insurance has paid. It is your responsibility to provide us with any future changes with your insurance.

I acknowledge that I have read and understand this. Please initial here_____

Financial Agreement

In Order to provide you with the highest quality dental care, we provide our patients with estimates of fees before dental treatment. In the event that your insurance does not pay the estimated amount, you as a patient, parent, and/or guardian are responsible for your balance. It is your responsibility to call your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility, and 10% yearly interest may be charged for balances not paid and collections fees if your account requires collection assistance. We provide payment options as: Cash, Check, Major Credit Cards and Care Credit. Don't hesitate to discuss payment options and questions prior to your treatment so you may have a relaxing and comfortable visit with us.

I acknowledge that I have read and understand this. Please initial Here_____