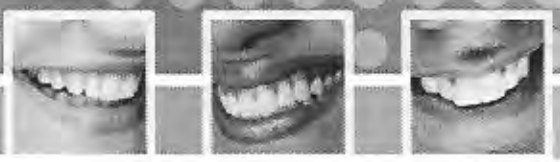
Research Parkway Dental, Professional LLC
2465 Research Parkway
Ste 100
Colorado Springs CO
(719)528-6450
info@toddrogersdental.com
www.toddrogersdental.com



Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

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)

Whom may we thank for referring you to our practice?

☐ Other Office ☐ Insurance ☐ Yahoo.com ☐ Google.com
☐ Gazette.com ☐ Gazette Paper ☐ Springs Value Add ☐ Yellow Pages
☐ Valley Courier ☐ GoToGuide

Other (name below)

_____

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Spouse or Responsible Party Information

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: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) Best time to call: _____

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

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Consent for Services

I, the undersigned, hereby to treatment as necessary or desirable to the care of the patient named above, for the diagnosis of dental disease, deformity, or treatment of dental pathology and emergencies. These procedures may include radiographs (X-rays), models, and intraoral examinations. In case of emergency, I consent to treatment as deemed necessary by the Doctor, with the understanding the procedures will be explained in advance whenever practical. I further give my consent to the use of local anesthesia and relaxants as required for dental treatment. I also acknowledge and accept full responsibility for payment for any services rendered, and agree to remit payment in-full at the time of services unless other arrangements are agreed to in advance by W. Todd Rogers Dental.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Relationship to Patient:

_____

NOTICE OF PRIVACY PRACTICES

I, _____, hereby certify that I have received a copy of the W. Todd Rogers Dental "Notice of Privacy Practices".

Signature: _____ Date: _____

Missed Appointment Policy

I understand that if I cancel or reschedule an appointment(s) within 24 hours of the scheduled appointment I may be charged and will be responsible to pay a missed appointment fee of $50. This policy allows our office to offer that time reserved to another patient.

Signature: _____ Date: _____

Response Date: _____

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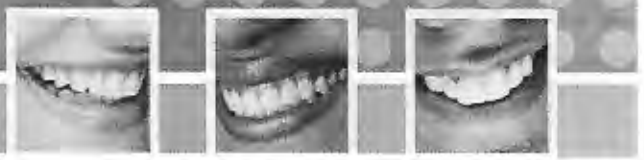

Medical & Dental History Form

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

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you:

☐ Trying to get pregnant ☐ Pregnant

☐ Nursing ☐ Taking oral contraceptives

☐ Beginning menopause ☐ Taking hormone replacements

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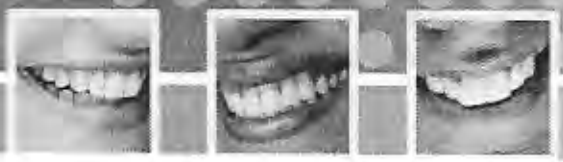

Please indicate if you do have or if you have ever experienced any of the following:

- ☐ AIDS/ARC/HIV Positive
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Angina/Chest pain
- ☐ Anorexia or Bulimia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Pressure, Low/High
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Canker Sores
- ☐ Cardiac Pacemaker
- ☐ Chemotherapy
- ☐ Cold Sores
- ☐ Congenital Heart Disorder
- ☐ Cortisone Treatment
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting or Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Glaucoma
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A, B, or C
- ☐ Herpes
- ☐ Hives or Rashes
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis Medication
- ☐ Pain in Jaw Joints
- ☐ Panic or Anxiety Attacks
- ☐ Parathyroid Disease
- ☐ Pre Med
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ Swelling of the Limbs
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Do you have any other health issues or allergies including medications?

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

I understand that the staff at Dr. W. Todd Rogers Dental office will update my medical and dental history form every 6 months if I have stated that there has been changes in my medical or dental history. I also understand that I will fill out a new medical and dental history form every 2 years.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

By checking this box, I acknowledge that I have read this statement, agree to the contents, and am giving my electronic signature.

Relationship to Patient:

_____

Response Date: _____

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Are you currently taking any prescription or non-prescription medications? If so, please list medication name and dosage:

When was your last visit to the dentist and what was done?

How frequently do you brush and floss your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

Do you have dental exams/cleanings on a routine basis?

◯ Yes ◯ No

Please mark any of the following to indicate Yes in response to the question:

☐ Have your past dental experiences been negative?

☐ Have you ever had complications following dental treatment?

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Do you have clicking, popping or discomfort in the jaw joint?

☐ Do you grind your teeth (either consciously or during sleep)?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

DOCTOR SIGNATURE ONLY

Signature: _____ Date: _____