

Please Complete the Following Confidential Information

IF THIS
APPOINTMENT
IS FOR YOU
START HERE

IF THIS
APPOINTMENT
IS FOR
YOUR CHILD
START HERE

Date _____ **1**

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Cell Phone _____

Birthdate _____ Age _____

Married ☐ Single ☐ Divorced ☐ Widow ☐

Soc Sec.# _____

Email _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____

Birthdate _____ Age _____

Grade _____ School _____

If your child's name and address are not the same as yours, please fill in the above box also

INSURANCE INFORMATION **2**

PRIMARY CARRIER

Carrier Name _____

Subscriber _____

Union or Local # _____

Aid or Local # _____

Member # _____

SECONDARY CARRIER

Carrier Name _____

Subscriber _____

Union or Local # _____

Aid or Group # _____

Member # _____

Soc. Sec # _____

ACCOUNT INFORMATION **4**

Person Responsible for Account

YOUR:

Name _____

Occupation _____

Employer _____

Business Address _____

City _____ State _____ Zip _____

Business Telephone _____ Ext. _____

YOUR SPOUSE:

Name _____

Occupation _____

Employer _____

Business Address _____

City _____ State _____ Zip _____

Business Telephone _____ Ext. _____

GETTING TO KNOW YOU **3**

Referred to us by _____

Is another member of your family, or relative a patient at our office? _____

Convenient appointment time _____

Are you available for appointments on short notice? _____

Purpose of this appointment _____

Closest relative not living with you _____ Phone _____

Patient Medical History

Physician _____

Office Phone _____

Date of Last Exam _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Do you have pain from any area of your mouth?..... | ☐ | ☐ |
| 2. Are you in good health?..... | ☐ | ☐ |
| 3. Are you under medical treatment now?..... | ☐ | ☐ |
| 4. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... | ☐ | ☐ |
| If yes, please explain _____ | | |
| 5. Are you taking any medications(s) including nonprescription medicine?..... | ☐ | ☐ |
| If yes, what medication(s) are you taking? _____ | | |
| 6. Do you use tobacco?..... | ☐ | ☐ |
| 7. Do you have or have you had any of the following? | | |

8. Are you allergic to or have you had any reactions to the following?

- | | Yes | No |
|---|--------------------------|--------------------------|
| Local Anesthetics (e.g. novocaine)..... | ☐ | ☐ |
| Penicillin or any other Antibiotics | ☐ | ☐ |
| Sulfa Drugs | ☐ | ☐ |
| Barbiturates..... | ☐ | ☐ |
| Sedatives | ☐ | ☐ |
| Iodine | ☐ | ☐ |
| Aspirin | ☐ | ☐ |
| Any Metals (e.g. Nickel, Mercury, etc.) | ☐ | ☐ |
| Latex Rubber | ☐ | ☐ |
| Darvon | ☐ | ☐ |
| Demerol | ☐ | ☐ |
| Percodan | ☐ | ☐ |
| Codeine | ☐ | ☐ |
| Nitrous Oxide | ☐ | ☐ |
| Nembutal/Seconal | ☐ | ☐ |
| Sleeping Pills | ☐ | ☐ |
| Other (please list) _____ | ☐ | ☐ |

*Prescribed antibiotics may render oral contraceptives ineffective

- | | Yes | No |
|---------------------------|--------------------------|--------------------------|
| High Blood Pressure..... | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Rheumatic Fever..... | ☐ | ☐ |
| Fainting/Seizures..... | ☐ | ☐ |
| Asthma..... | ☐ | ☐ |
| Epilepsy/Convulsions..... | ☐ | ☐ |
| Diabetes..... | ☐ | ☐ |
| Heart Disease..... | ☐ | ☐ |

- | | Yes | No |
|-----------------------------------|--------------------------|--------------------------|
| Cardiac Pacemaker..... | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Angina..... | ☐ | ☐ |
| Cancer..... | ☐ | ☐ |
| Arthritis..... | ☐ | ☐ |
| Joint Replacement or Implant..... | ☐ | ☐ |
| Hepatitis/Jaundice..... | ☐ | ☐ |
| Sexually Transmitted Disease..... | ☐ | ☐ |

- | | Yes | No |
|----------------------------|--------------------------|--------------------------|
| Hay Fever/Allergies..... | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Liver Disease..... | ☐ | ☐ |
| Heart Trouble..... | ☐ | ☐ |
| Respiratory Problems..... | ☐ | ☐ |
| Mitral Valve Prolapse..... | ☐ | ☐ |
| Other | ☐ | ☐ |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 9. Do you have any disease, condition, or problem not listed above that you think we should know about?..... | ☐ | ☐ |
| 10. Have you had any orthodontic treatment?..... | ☐ | ☐ |
| 11. Are you unhappy with the appearance of your teeth?..... | ☐ | ☐ |
| 12. Do you have discolored teeth that bother you?..... | ☐ | ☐ |
| 13. Would you like your smile to look better or different?..... | ☐ | ☐ |
| 14. Is there any information you would like to know from us?..... | ☐ | ☐ |

Date _____ Signature _____

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

Agreement

IN CONSIDERATION OF TREATMENT BY THE DOCTOR, THE UNDERSIGNED AGREES:

I hereby authorize payment directly to Dr. Kelly D. Carroll D.D.S. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Dr. Kelly D. Carroll and/or such associates or assistants as he/she may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic therapeutic, and/or other pharmaceutical agent(s), including those related to restorative palliative, therapeutic or surgical treatment. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my Minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

MEDIATION/ARBITRATION AGREEMENT: any claim or controversy between the patient and/or legally authorizes representative of the patient and dentist concerning the care and treatment rendered by the dentist to the patient shall be resolved by mediation or arbitration according to the rules of the WESTERN MEDIATION. A claim or controversy shall first be submitted to binding arbitration. Judgement(s) on the decision achieved through mediation or rendered by arbiter(s) can be entered in any court having jurisdiction thereof. The information on this page and the information about my dental treatment to third party payers and/or other health professionals.

To pay the amount charged by the doctor for all professional treatment and services to the undersigned, his family, or the patient indicated about: payment to be made by me to Dr. Kelly D. Carroll D.D.S. P.C.

That if payments are extended beyond 30 days from date of first billing, to pay 1 1/2% per month on the unpaid balance. Annual percentage rate of 18% minimum monthly charge \$0.50. To pay all collection fees, court costs and reasonable attorneys fees in the event of suit of referral to collect.

Dated this _____ day of _____ 20 _____ responsible party _____

Relationship to patient _____