CARROLL DENTAL ASSOCIATES
CARROLL IOWA

Welcome!

Thank you for choosing us for your dental needs.

Patient Information (Confidential)

Date _____

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Cell Phone _____

SS Number _____ Place of Employment _____

Spouse/Parent Name _____ Work Phone _____

Spouse/Parent SS Number _____ Spouse/Parent Date of Birth _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account? _____ Relationship _____

For your convenience, we offer the following methods of payment. Please check the option you prefer:

___Cash ___Personal Check ___Credit Card ___Automatic Withdrawal for Payments

Insurance Information

Name of insured as it appears on insurance card _____

Relationship _____ Date of Birth _____ Through work? Name of Employer _____

Name of insurance company and mailing address with customer service number _____

_____

Unique ID Number on insurance card and/or social security number _____

CARROLL DENTAL ASSOCIATES
CARROLL IOWA

ADULT HEALTH HISTORY

(Confidential)

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

What is the name of your physician? _____

_____

Physician's office phone number:_____

What is the date of your last physical examination? (Month/Year) _____

Are you currently under the care of a physician: Yes ____ No _____

If yes, what is/are the condition(s) being treated?_____

_____

Has there been any change to your general health within the past year? Yes _____ No_____

Please specify condition: _____

_____

Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes_____ No _____

If yes, what was the illness or problem?_____

_____

Have you had an orthopedic total joint (ex. hip, knee, elbow) replacement? Yes _____ No _____

If yes, what joint was replaced, when was it replaced, and have you had any complications?_____

_____

_____

Have you had any radiation therapy, or chemotherapy for a growth tumor, or other condition? Yes __ No __

If yes, please specify _____

_____

CARROLL DENTAL ASSOCIATES
CARROLL IOWA

Health History (Continued)

Have you taken, or are you taking, or are you scheduled to begin taking oral or IV bisphosphonates? (Ex. Alendronate (Fosamax), Ibandronate (Boniva), Risedronate (Actonel)? Yes ____ No ____

If yes, what drug, dose, and frequency? _____

_____

If yes, what for _____

_____

If yes, please specify when you began taking, are scheduled to begin taking, or when was the last time you were taking oral or IV bisphosphonates.

_____

_____

Are you currently taking a blood thinner such as Coumadin, Warfarin or Aspirin? Yes_____No _____

If yes, please specify _____

_____

Do you use tobacco (smoking, snuff, chew)? Yes_____No _____

If yes, please specify amount per day _____

If yes, are you interested in stopping?

____ Very ____ Somewhat____Not Interested

Women Only

Are you pregnant or think you may be pregnant? Yes____No ____

If yes, number of weeks? _____

Are you nursing? Yes ____ No _____

CARROLL DENTAL ASSOCIATES
CARROLL IOWA

Health History (Continued)

MEDICATIONS

Please list any medication, dose, and frequency: (Please include non-prescription medications and herbal supplements such as Ginkgo, fish oil and vitamins)_____

_____

_____

MEDICAL CONDITIONS

Do you have any of the following?

- ❑ High Blood Pressure
- ❑ Fainting/Seizures
- ❑ Epilepsy/Convulsions
- ❑ Kidney Disease
- ❑ Heart Disease
- ❑ Angina
- ❑ Emphysema
- ❑ Joint Replacement or Implant
- ❑ Stomach Troubles/Ulcer
- ❑ Easily Winded
- ❑ Tuberculosis
- ❑ Recent Weight Loss
- ❑ Respiratory Problems
- ❑ Alzheimers/Dimentia
- ❑ Heart Attack
- ❑ Asthma
- ❑ Leukemia
- ❑ AIDS or HIV Infection
- ❑ Cardiac Pacemaker
- ❑ Organ Transplant
- ❑ Cancer
- ❑ Hepatitis/Jaundice
- ❑ Acid Reflux/Heartburn
- ❑ Stroke/TIA
- ❑ Radiation Therapy
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Bleeding/Clotting Problems
- ❑ Rheumatic Fever
- ❑ Low Blood Pressure
- ❑ Diabetes
- ❑ Thyroid Problem
- ❑ Heart Murmur
- ❑ Anemia
- ❑ Arthritis
- ❑ Sexually Transmitted Disease
- ❑ Chest Pains
- ❑ Hay Fever/Allergies
- ❑ Glaucoma
- ❑ Heart Trouble
- ❑ COPD
- ❑ Other

If you have any condition listed above, or any other condition or problem not listed above, please specify:

_____

_____

Have you ever sought treatment for drug or alcohol dependence? Yes _____ No_____

If yes, please specify _____

CARROLL DENTAL ASSOCIATES
CARROLL IOWA

Health History (Continued)

ALLERGIES

Are you allergic to or have you had any reaction to any of the following?

- ❑ Local anesthetics (Novocaine/epinephrine)
- ❑ Sulfa drugs/or other antibiotics
- ❑ Metals/jewelry (nickel/chrome)
- ❑ Other medication
- ❑ Penicillin
- ❑ Codeine or other narcotics
- ❑ Latex
- ❑ No known drug allergies

Please specify type of reaction: _____

_____

Family history of diabetes? Yes _____ No _____

Family history of heart disease? Yes _____ No _____

Family history of cancer or tumors? Yes _____ No _____

Signature _____Date_____Response Date _____

Thank you for taking the time to fill out this form!

CARROLL DENTAL ASSOCIATES
CARROLL IOWA

ASSIGNMENT OF BENEFITS

I voluntarily direct _____ Insurance company (or Attorney at Law) to pay members of Carroll Dental Associates (Dr. Karl Eischeid, Dr. Nicholas Fangman, Dr. Marie G'Sell, Dr. Martin Halbur and Dr. Michelle Sturm) directly for charges for professional services rendered to me. THIS IS A DIRECT ASSIGMENT OF BENEFITS UNDER THIS POLICY. I agree that I am responsible for any balance over and above insurance/attorney payments for these services. I understand and agree that if collection efforts are necessary to obtain payment on this account, I will be responsible for all costs of such collection efforts, including reasonable attorney fees.

I UNDERSTAND THAT ANY UNPAID BALANCE WILL ACCRUE MONTHLY INTEREST AT 1.5 % AFTER 30 DAYS OF DELINQUENCY, UNLESS PRIOR PAYMENT ARRAGNEMENTS ARE MADE.

CONSENT TO TREAT

I voluntarily authorize members of Carroll Dental Associates and whomever Dr. _____ designates as assistants or associates to administer examinations and care as deemed necessary for my condition.

APPOINTMENTS

Any missed appointments without 24 hours notice, except in an emergency, will be documented. Multiple missed appointments will lead to dismissal from the practice.

PATIENT OR PARENT/GUARDIAN
SIGNATURE_____

DATE _____

CARROLL DENTAL ASSOCIATES
CARROLL IOWA

Karl J. Eischeid DDS, Nicholas J. Fangman DDS, Marie C. G'Sell DDS, Martin J. Halbur DDS, Michelle N. Sturm DDS

Receipt of Notice of Privacy Practices

---

* You May Refuse to Sign This Acknowledgment *

I have been offered a copy of this office's Notice of Privacy Practices effective January 1st, 2014.

Print Patient Name: _____

Signature of Patient or Person Authorized to Consent: _____

Patient's Relationship to Authorized Person: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)