CARROLL
DENTAL LABORATORY, INC.
110 West King Street • Kinston, NC • 28501 • Tel: 1.800.359.2455

# Doctor Preferences

**Return form to Dianna Carroll at cdl-dianna@suddenlinkmail.com, by driver, by mail or fax to 252-522-4612.**

**Doctor's Name:** _____ **Practice Name:** _____

**Fax Number:** _____ **E-Mail Address:** _____

**Preferred Method of Contact:**

☐ **Telephone:** _____ ☐ **E-Mail:** _____

**Preferences**

1. **Dies:** ☐ Ditch in Lab ☐ Send back for doctor to ditch
2. **PFM Collars:** ☐ Posterior ☐ Anterior ☐ Only when requested
   **Shape (half-moon, full, etc.):** _____
3. **Proximal Contacts:** ☐ Tight ☐ Firm ☐ Loose ☐ Other:
4. **Occlusal Contacts:** ☐ Touching ☐ 0.5 mm clearance ☐ 1.0 mm clearance ☐ Other:
5. **If occlusal space is not adequate, which would you prefer that we do:**
   ☐ Relieve the Opposing Tooth ☐ Place a metal island
   ☐ Metal Occlusal ☐ Call you for instructions

**6. Preferred metal for PFMs:** ☐ High Noble ☐ Noble ☐ Base/Non-precious

**7. Preferred metal for Full Cast Crowns:** ☐ High Noble ☐ Noble ☐ Base/Non-precious

**8. Payment Preference:** ☐ Pay by Check ☐ Pay with Credit Card on File ***(complete form on back)***

**Other Preferences:** _____

_____

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# PRE-AUTHORIZATION CREDIT CARD APPROVAL AGREEMENT

Cardholder's Name: _____

Practice Address: _____

City: _____ State: _____ ZIP: _____

Phone: (  ) _____ Fax: (  ) _____

Credit Card Billing Address: _____

City: _____ State: _____ ZIP: _____

Phone: (  ) _____ Fax: (  ) _____

E-Mail Address (*required*): _____

VISA/MasterCard/AMEX #:_____

Expiration Date: _____ CVV Code (3-digit code on back of card):_____

This Agreement is between the Cardholder (above) and ***Carroll Dental Laboratory, Inc***. The Agreement shall become effective upon signature of Cardholder. I hereby certify that the information provided on the Agreement is true, correct and complete as of the date indicated below. I agree to promptly notify ***Carroll Dental Laboratory, Inc***. of any changes in the information provided.

I hereby authorize ***Carroll Dental Laboratory, Inc.*** to charge my credit card for work completed as indicated above on the 1st of each month (or the following business day). This Pre-Authorization shall remain in effect until I notify ***Carroll Dental Laboratory, Inc***. in writing of its cancellation.

_____ _____

Cardholder's Signature Date

**Please complete and return to Dianna Carroll by fax (252-522-4612) or e-mail (cdl-dianna@suddenlinkmail.com). Thank you!**