Carlton Dental

Welcome. *Thank you for selecting our dental healthcare team! We will Strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out the form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.*

Patient Information (CONFIDENTIAL)

Name________________________________ Birthdate______________ Date________________

Address______________________________ City______________ State__________ Zip__________

Phone: Home______________ Cell______________ Work______________ SS#______________ DL#______________

Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

If student, name of School/College______________________ City__________ State______ Full Time ☐ Part Time ☐

Employer____

Business Address______________________________ City______________ State______ Zip__________

Spouse or Parents Name______________________ Employer______________________ Work Phone______________

Whom may we thank for referring you?____

Responsible Party (If different from above)

Name of person responsible for this account______________________________ Birthdate______________

Address______________________________ City______________ State__________ Zip__________

Phone: Home______________ Cell______________ Work______________ SS#______________ DL#______________

Employer________________ Address______________________ City______________ State______ Zip__________

Insurance Information

Name of Insured______________________________ Relation to Patient______________________

Birthdate________________ SS#______________________ Date Employed______________________

Name of Employer______________________ Union or Local#________________ Work Phone______________

Address of Employer______________________________ City______________ State__________ Zip__________

Insurance Company______________________ Group #______________________ Policy/ID #______________

Ins. Co. Address______________________________ City______________ State__________ Zip__________

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes ☐ No ☐ IF YES, COMPLETE THE FOLLOWING:

Name of Insured______________________________ Relation to Patient______________________

Birthdate________________ SS#______________________ Date Employed______________________

Name of Employer______________________ Union or Local#________________ Work Phone______________

Address of Employer______________________________ City______________ State__________ Zip__________

Insurance Company______________________ Group #______________________ Policy/ID #______________

Ins. Co. Address______________________________ City______________ State__________ Zip__________

Over Please