

Oleander Family & Cosmetic Dentistry, LLC

Edward V. Horton, Jr., DDS, PA

Robert S. Merritt, DMD, PC

Patient Registration

Date: _____

Patient's Name: _____
Last First M.I. Preferred Name

Home Address: _____ City _____ State _____ Zip _____

Phone: _____ Cell: _____ E-Mail: _____

Single Married Widowed Divorced

Birthdate: _____ Male Female

Employed by: _____ Occupation: _____

Retired: _____ If yes, previous occupation (optional) _____

Self Employed (type of business): _____

Business Address: _____ Business Phone: _____

Spouse Name: _____ Spouse Employed by: _____

Business Address: _____ Business Phone: _____

Who is responsible for this account: _____ Relationship to Patient: _____

Name of dental insurance company: _____ Gp#/or Subscriber SSN: _____

Address: _____

If you are currently covered by a dental insurance plan, as a courtesy to you, we will assist you in submitting pre-treatment estimates when necessary, and we will file your claim. We do not accept insurance payment for our fees. The contract exists between you and your dental insurance company. We will request that your insurance company **reimburse you directly**. Please provide our office with your dental insurance card and a copy of your claim form so we may assist you better.

In case of emergency, who should be notified? _____ Phone/Cell _____

WHO MAY WE THANK FOR REFERING YOU? _____