Patient Registration

Patient Information

First Name

Middle Initial

Last Name

Date of birth

Gender

Address, if changed

Cell Phone #

Home Phone #

E-mail:

Emergency Contact

Emergency Contact Phone Number

Billing and Insurance Information

Person Responsible for Bill

Phone Number (if different)

Address (if different)

Primary Insurance Carrier

Subscriber's Name

Patient's Relationship to Subscriber

Subscriber's Date of Birth

Subscriber's Social Security Number

Policy Number

Group Number

How did you hear about us?

Please choose an option

Signature

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Easy Dental Care or insurance

company to release any information required to process my claims.

Signature