

Patient Registration

Patient Information

First Name _____

Middle Initial _____

Last Name _____

Date of birth _____

Gender _____

Address, if changed

[Large empty text box for address]

Cell Phone # _____

Home Phone # _____

E-mail:

[Large empty text box for email]

Emergency Contact _____

Emergency Contact Phone Number _____

Billing and Insurance Information

Person Responsible for Bill _____

Phone Number (if different) _____

Address (if different)

[Large empty text box for address]

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?

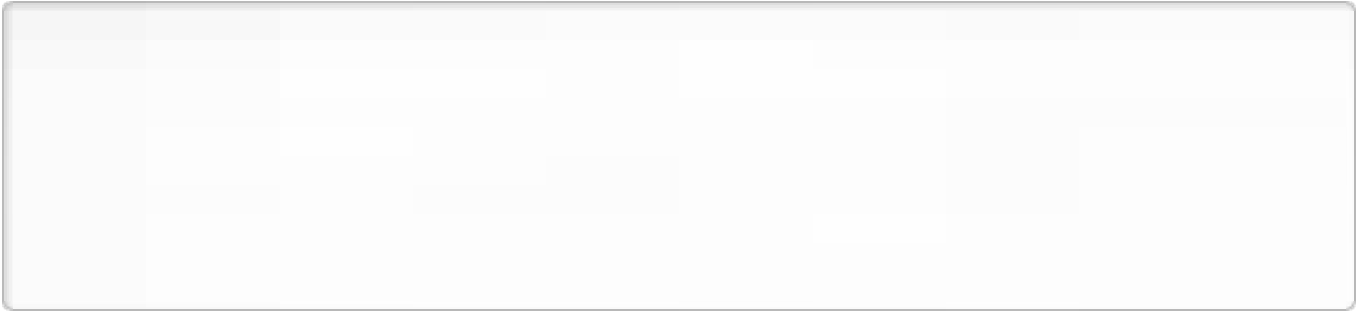
Please choose an option _____

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

A large, empty rectangular box with rounded corners, intended for a signature. The box is light gray and occupies a significant portion of the page below the 'Signature' label.