East Main
Dental
Center, LLP

GREGORY L. PEARSON, DMD
HAL L. BORG, DMD
KENNETH D. McGOWAN, DMD
IAN KITTELSON, DMD

INSURANCE COMPANY AND PHONE NUMBER: _____

MEMBER ID#: _____ GROUP #: _____ EFFECTIVE DATE: _____

INSURED MEMBER'S EMPLOYER: _____

NAME OF INSURED MEMBER: _____

INSURED DATE OF BIRTH: _____ INSURED SOCIAL SECURITY #: _____

INSURED ADDRESS: _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION RELATED TO CLAIMS, AND PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, NOT TO EXCEED THE CHARGES SHOWN. I AUTHORIZE EAST MAIN DENTAL CENTER, LLP TO CONTACT MY EMPLOYER OR INSURANCE AGENT TO OBTAIN THE NECESSARY INFORMATION TO PROCESS THE ABOVE MENTIONED CLAIMS AND PAYMENTS.

_____ DATE

_____ SIGNATURE