



East Main
Dental
Center, LLP

PATIENT INFORMATION

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

Patient's Name _____				
Preferred Name _____		Sex _____		Birthdate _____
Address _____		City _____		State _____ Zip _____
Email Address: _____				
How long at this address _____		Home Phone _____		Cell Phone _____ Work Phone _____
Previous Address (if less than 3 years) _____				
Social Security # _____		Marital Status _____		Occupation _____
Employer _____		No. Years Employed _____		
How did you learn about our office? _____				

☐ Check box if same as above

Responsible Party Information

Name _____				
Address _____		City _____		State _____ Zip _____
How long at this address _____		Home Phone _____		Cell Phone _____ Work Phone _____
Previous Address (if less than 3 years) _____				
Social Security # _____		Birthdate _____		Relationship to Patient _____
Employer _____		No. Years Employed _____		

Responsible Party's Spouse Information

Name _____				
Employer _____		Occupation _____		No. Years Employed _____
Social Security # _____		Birthdate _____		Work Phone _____

Emergency Information

Name of nearest relative not living with you _____				
Complete Address _____				
Phone _____				

Billing Information

Do you have Dental Insurance? ☐ Yes ☐ No Secondary? ☐ Yes ☐ No Will we be billing your insurance? ☐ Yes ☐ No

Please read and initial: _____

I understand that I am responsible for charges regardless of any amounts that may be paid by my insurance. I further understand that the amount collected at the time of service is based on the ESTIMATED amount the insurance will cover based on the information currently available.

I authorize treatment for the person named above and agree to pay all fees and charges for such treatment.

Signature _____ Date _____