East Main Dental Center, LLP

PATIENT INFORMATION

GREGORY L. PEARSON, DMD
HAL L. BORG, DMD
CALIE ROA, DMD
ERIC N. ALSTON, DMD
KENNETH D. McGOWAN, DMD

Patient's Name _____
Last First Middle

Preferred Name _____ (Legal) _____ (Legal) Sex _____ Birthdate _____

Address _____
Street City State Zip

Email Address: _____

How long at this address ____ Home Phone _____ Cell Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

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 _____ _____
Last First Middle Marital Status

Address _____
Street City State Zip

How long at this address ____ Home Phone _____ Cell Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ No. Years Employed _____

Responsible Party's Spouse Information

Name _____
Last First Middle

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 choose one of the following options:

I understand that a credit bureau report will be obtained for all new patients, and for patients of record when appropriate.

_____
Please initial to accept this statement or the statement below

I do not want a credit bureau report obtained. I will pay in full for all treatment at each appointment regardless of insurance benefits.

_____
Please initial to accept this statement

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

Signature _____ Date _____