LARRY A. JOHNSON, DDS, PC
PRACTICE LIMITED TO PERIODONTICS AND IMPLANTS

PATIENT:

NAME:_____BIRTHDATE_____PHONE_____

ADDRESS:_____CITY_____STATE__ZIP_____

PATIENT'S OR PARENT'S EMPLOYER_____WORK #_____

SPOUSE OR PARENT'S NAME_____EMPLOYER_____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE_____

WHOM MAY WE THANK FOR REFERRING YOU?_____
PERSON TO CONTACT IN CASE OF EMERGENCY_____

NAME OF DENTIST:_____
NAME OF PHYSICIAN:_____

INSURANCE INFORMATION:

NAME OF INSURED_____RELATIONSHIP_____

BIRTHDATE_____INSURANCE ID NUMBER_____

NAME OF EMPLOYER_____WORK PHONE_____

INSURANCE COMPANY_____GROUP NO._____

INS. CO. ADDRESS_____

SECONDARY INSURANCE_____

NAME OF EMPLOYER_____WORK PHONE_____

INSURANCE COMPANY_____GROUP NO._____

INSURANCE CO. ADDRESS_____

SIGNATURE OF PATIENT OR PARENT IF MINOR:
_____DATE_____