



# KENT JOHANSEN, D.D.S.

*Dentistry & Orthodontics*  
3800 West Ray Road, Suite 11  
Chandler, Arizona 85226  
(480) 345-0530

## Welcome!

*Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.*

### ABOUT YOU ... [Please Print]

Date: \_\_\_\_\_

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
First Middle Last

Street City State Zip Cell Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_ E-Mail \_\_\_\_\_

Street City State Zip

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ M F Social Security Number \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ Position \_\_\_\_\_

Street City State Zip

TO CONFIRM APPTS, YOU MAY CONTACT ME (CIRCLE) HOME WORK CELL E-MAIL

Whom may we thank for referring you? \_\_\_\_\_

### SPOUSE INFORMATION ...

His/Her Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address (if different) \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Driver's License # \_\_\_\_\_

### DENTAL INSURANCE ...

#### PRIMARY CARRIER

Subscriber's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ SS# / ID# \_\_\_\_\_

Ins. Company Name \_\_\_\_\_ Group Number \_\_\_\_\_

Ins. Company Address \_\_\_\_\_ Phone \_\_\_\_\_

#### SECONDARY CARRIER

Subscriber's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ SS# / ID# \_\_\_\_\_

Ins. Company Name \_\_\_\_\_ Group Number \_\_\_\_\_

Ins. Company Address \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency, please contact the following relative or friend:

Name \_\_\_\_\_ Address \_\_\_\_\_

Day Time Phone \_\_\_\_\_ Relation: \_\_\_\_\_ Friend

