Dave Johnson Dental Laboratory, Inc.

New Customer Registration

Doctor & Practice Information

Dr. Name _____
First *Last* *License Number*

Dental Practice Name _____

Street Address _____

City, State, Zip _____

Phone _____ Email _____

Other dentists at your practice, if any:

_____

Billing Contact Information

We send monthly statements by email and follow up by phone when needed for billing purposes. Please provide the following information for the person in your office in charge of finances. This may be an accountant, office manager, office assistant, etc.

Name _____ Title/Position _____

Email _____ Phone _____

Additional Office Contacts (Optional)

If you have a specific contact person for any of these items, please provide their name and title/role. Provide email addresses and phone numbers if different from the general office info given above.

Office Manager _____

Scheduling _____

Treatment/Case Information _____

Other _____

*Please scan and email completed form to DaveJohnsonDentalLabInc@gmail.com (preferred), **or** mail a hard copy to 1006 N. Salisbury Blvd, Unit A, Salisbury MD 21801.*