Leo Family DENTAL
8 Main Street, Suite 6
Flemington, NJ
Phone: 908-782-6606 Email: leofamilydental@gmail.com Fax: 908-782-1757

PATIENT REGISTRATION FORM

Patient Information

Name: _____ Date of Birth: _____Social Security#: _____

Gender: ◯Female ◯Male Marital Status: ◯Single ◯Married ◯Other: _____

Home Address: _____

Mailing Address: _____

Home Phone#: _____Mobile Phone#: _____

E-mail Address: _____

Over 18 years old? ◯ Yes ◯ No, Name of Parent/Legal Guardian: _____

Employer: _____ Work Phone#:_____

Employer Address: _____

*How did you hear about us? _____

*Please Present **Insurance Card**(s) and Federal/**State Issued I.D.** to Our Office Upon Arrival, Thank You.*

Insurance Information

Primary Dental Insurance: ◯Yes, *please present **Insurance Card** to Front Desk staff.* ◯No

Are you the Subscriber? ◯Yes ◯No

If No, Subscriber's Name: _____

Relationship to Subscriber: _____ Subscriber's SS#: _____

Emergency Contact Information

Emergency Contact Name:_____ Relationship to Patient:_____

Emergency Contact Phone#: _____

Emergency Contact Address: _____

I hereby certify that the above statements are true and correct to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRATICES

I, _____have received a copy of Notice of Privacy Practices from Leo Family Dental LLC.

Patient/Guardian Signature: _____ Date: _____