



PATIENT REGISTRATION

Patient Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ ext: _____

E-mail: _____ Cell Phone: _____

DOB: _____ SEX: MALE FEMALE Social Security #: _____

If patient is a minor, parent's or guardian's name: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____ Secondary Phone Number: _____

Preferred Pharmacy: _____ Address: _____

Who referred you to our office: _____

Reason for this visit: _____

Responsible Party/Insurance Information

Insured's Name (If different from Patient): _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Social Security #: _____ DOB: _____

Employer: _____ Insurance Company: _____

ID #: _____ InsuranceCompanyAdress: _____

Group #: _____ Phone#: _____

Do you have Dual Coverage? YES NO If yes, please complete the secondary insurance information.

Insured's Name: _____ Insured's DOB: _____

ID#orSS#: _____ Insurance Company: _____

Insured's Employer: _____ Ins.CO address: _____

Group#: _____ Phone#: _____

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