



*Maria G. Duque, D.D.S. Dental Arts*

Patient Registration Form

Purpose of today's visit: \_\_\_\_\_

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

Patient's Name: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_\_ Social Security Number (SSN): \_\_\_\_\_

Name of Spouse, if applicable \_\_\_\_\_ If a Minor, Parent's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Personal Cell Phone: \_\_\_\_\_

Personal Email Address: \_\_\_\_\_

In case of emergency, who should we notify?: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Employed by: \_\_\_\_\_ Position / Title: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Cell Phone: \_\_\_\_\_

Business Email Address: \_\_\_\_\_

Spouse Employed By: \_\_\_\_\_ Spouse's Business Phone: \_\_\_\_\_

Who will be financially responsible for this account? \_\_\_\_\_

Does Patient have dental insurance that will cover at least a portion of services rendered?:  Yes  No

If Yes, name of Insurance Company: \_\_\_\_\_ Group / Policy Number: \_\_\_\_\_

If covered by insurance, list the Social Security Number (SSN) of policy holder:: \_\_\_\_\_

If covered by insurance, list the Date of Birth (DOB) of policy holder:: \_\_\_\_\_

If Patient has secondary dental insurance coverage, please provide information:: \_\_\_\_\_

***Insurance is a contract between you and your insurance provider. While we are happy to assist you in getting the maximum level of benefits from your provider the responsibility for reimbursement of our fees ultimately lies with the Patient.***

By signing below patient acknowledges that information provided above is to the best of patient's recollection and understanding.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_