Drs. Love & Miller, P.C.

Patient Registration

Please Complete the Following Confidential Information

IF APPOINTMENT IS FOR *YOU*, START HERE

Date

Last Name | First | M.I.

Prefers to be Called By

Address

City | State | Zip

Phone | Fax

Mobile | Email

Birth Date | Age | ❒ Male | ❒ Female

❒ Married | ❒ Single | ❒ Divorced | ❒ Widowed

Social Security No.

IF APPOINTMENT IS FOR *YOUR CHILD*, START HERE

Date

Last Name | First | M.I.

Address

City | State | Zip

Phone

Birth Date | Age | ❒ Male | ❒ Female

School | Grade

Social Security No.

If Your Child's Last Name and/or Address are Not the same as Yours, Fill in the Top Box Also

DENTAL INSURANCE

PRIMARY CARRIER

Insurance Company

Group No.

Employer Name

Insured's Name

Birth Date

Relationship to Patient

Insured's I.D. No.

Insured's Social Security No

SECONDARY CARRIER

Insurance Company

Group No.

Employer Name

Insured's Name

Birth Date

Relationship to Patient

Insured's I.D. No.

Insured's Social Security No

GETTING TO KNOW YOU

Is another member of your family or relative a patient at our office?

Name

Relationship

You were referred to us by

Your former address

City | State | Zip

Person to contact for emergency

Phone

Address

City | State | Zip

Closest relative not living with you

Phone

Address

City | State | Zip

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name

Relationship to Patient

Social Security No.

Address

City | State | Zip

Phone

YOU

Name

Occupation

Employer's Name

Address | City

Phone | Fax

YOUR SPOUSE

Name

Occupation

Employer's Name

Address | City

Phone | Fax

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Complete other side