Compassionate Dentistry, P.C
Scott B. Boltz, D.D.S.
310 East Alto Road, Kokomo IN 46902-3674
765 864-2328 • Fax 765 864-2333

PATIENT REGISTRATION

First Name: ______________________ Last Name: ______________________

Address: ______________________ Address 2: ______________________

City: ______________________ State / Zip: ______________________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

E-mail: ______________________ Which contact do you prefer (circle one): Home Phone Cell Phone Work Phone Email Text

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: ____________ Age: ______ Soc. Sec: ______________________

Pharmacy Name: ____________________ Pharmacy #: ____________________

If minor, Mother: ____________________ Father: ____________________

Patient is: ☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: ______________________ Last Name: ______________________

Address: ______________________ Address 2: ______________________

City, State, Zip: ____

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Birth Date: ____________ Soc. Sec: ______________________

☐ I authorize Compassionate Dentistry, and those parties acting on behalf of Compassionate Dentistry, to contact me to remind me to schedule appointments for health services.

INSURANCE INFORMATION

MEDICAL INSURANCE

Subscriber's Name______________________ Relationship to Patient______________________

Subscriber's DOB:________/_________/________ Subscriber's SSN#______________________

Insurance Company______________________ Policy#____________ Group#____________

DENTAL INSURANCE

Insured's Name______________________ Relationship to Patient______________________

Insured's DOB:_______/________/_________SSN#______________________Employer______________________

Insurance Company(Name, Address)____

Policy#______________________ Group#______________________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE [ ] Yes [ ] No If yes, please complete the following:

Insured's Name______________________ Relationship to Patient______________________

Insured's DOB:_______/________/_________ SSN#______________________ Employer______________________

Insurance Company(Name, Address)____

Policy#______________________ Group#______________________