

Oakwood Hills Family Dental Patient Registration

First Name _____ Middle Initial _____ Last Name _____
Address _____ City _____ Zip _____
Cell Phone _____ Text OK? _____ Home Phone _____
DOB _____ Email Address _____

Primary Insurance Information:

Policyholder Name _____ Policyholder DOB _____
Policyholder Address _____ PH _____
Policyholder ID # or SS# _____ (we require a copy of ins card also)
Policyholder Employer _____ Group # _____
Name of Ins Co _____ Ins Phone _____
Other Family Members Cov'd _____

Secondary Insurance Information

Policyholder Name _____ Policyholder DOB _____
Policyholder Address _____ PH _____
Policyholder ID # or SS# _____ (we require a copy of ins card also)
Policyholder Employer _____ Group # _____
Name of Ins Co _____ Ins Phone _____
Other Family Members Cov'd _____

If under age 18:

Responsible Party Name _____
Responsible Party Address _____ City _____ Zip _____