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 _____ Phone # _____

Policyholder ID # or SS# _____ (we require a copy of ins card also)

Policyholder Employer _____ Group # _____

Name of Ins Co _____ Ins Phone # _____

Other Family Members Covered: _____

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 Covered: _____

If under age 18:
Responsible Party Name _____

Responsible Party Address _____ City _____ Zip _____