CCDA Calhoun Clemson
DENTAL ASSOCIATES, LLC

Patient Registration

Name: _____
Last *First* *M.I.* *Preferred Name*

Address: _____

Date of Birth: _____ **Gender**: □ Male □ Female **Social Security #:** _____

Marital Status: _____ **Occupation:** _____ **Email:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Emergency Contact:

Name: _____

Relationship: _____ **Phone Number:** _____

Primary Insurance Information

Name of Insured: _____ **Relationship to Patient:** _____

Insurance Company Name: _____

Insured DOB: _____ **Insured SSN#:** _____ **Member ID#:** _____

Insured Employer: _____

Secondary Insurance Information

Name of Insured: _____ **Relationship to Patient:** _____

Insurance Company Name: _____

Insured DOB: _____ **Insured SSN#:** _____ **Member ID#:** _____

Insured Employer: _____