WEST ASHLEY
FAMILY DENTISTRY

Dr. Agatha J Lynn Dr. James W. Dickert

PATIENT INFORMATION

Today's Date: _____

Patient Name: _____

Preferred Name: _____

Birth date: _____ Age: _____

Address: _____

_____

_____

Email: _____

Phone: Home: _____

Cell: _____

Work: _____Ext:_____

Gender: M/F □ Married □ Widowed □ Separated
□ Divorced □ Single □ Minor

Social Security #: _____

Occupation: _____

Employer: _____

School: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____

Relation: _____

Home: _____

Cell: _____

Work: _____

Whom may we thank for referring you?

Name: _____

□ Website □ Sign □ Other

□Search Engine: _____

How would you prefer to receive appointment reminders?

□ Text □ Email □Call Cell □Call Work □Call Home

DENTAL INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's Employer: _____

Group/Plan #: _____

Subscriber's Birth date: _____

Subscriber's Social Security #: _____

Secondary Insurance: _____

Subscriber's Name:

_____

Subscriber's Employer:

_____

Group/Plan #: _____

Subscriber's Birth date: _____

Subscriber's Social Security #: _____

Assignment and Release: I certify that I, and/or my dependant(s) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claims. The above named dentist may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

By signing this document, I agree to give Dr. Lynn and Dr. Dickert permission to distribute any relevant treatment or medical information to specialists that may be included in my treatment plan.

Responsible Party: (Print) _____ **Signature: _____**