Agatha J. Lynn, D.M.D.   James W Dickert, D.M.D.

PATIENT INFORMATION

Today's Date ____ Patient Name ____ Preferred Name ____

Birthdate ____ Email ____ Gender ____

Cell Phone ____ Home Phone ____ Work Phone ____

Address ____

Social Security # ____ Occupation ____ Employer ____

Preferred Method of Contact ◯ Text Message ◯ Email ◯ Call Cell ◯ Call Work ◯ Call Home

Emergency Contact ____ Relation ____ Cell ____ Work ____

Whom may we thank for referring you? ____ ☐ Website ☐ Sign ☐ Search Engine ____

Primary Insurance Information

Carrier Name ____ Group/ Plan Number ____ Employer ____

Subscriber Name ____ Subscriber Birthdate ____ Social Security # ____

Member ID# ____

Insurance Carrier Phone Number ____

Secondary Insurance Information

Carrier Name ____ Group/ Plan Number ____ Employer ____

Subscriber Name ____ Subscriber Birthdate ____ Social Security # ____

Member ID# ____

Insurance Carrier Phone Number ____

Assignment and Release

By printing my name below, I certify that I, and/or my dependant(s) have insurance coverage through the carriers listed above and assign directly to West Ashley Family Dentistry consent to file insurance claims for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance claims. I understand that West Ashley Family Dentistry and their representatives 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 payble for related services. I understand that at their discretion, West Ashley Family Dentistry will collect payment in full from me at the time of service and elect to have insurance benefit payments made directly to me, the patient.

Consenting Adult Name ____