WEST ASHLEY
FAMILY DENTISTRY
Dr. Agatha J. Lynn Dr. James W. Dickert
811 St Andrews Blvd, Suite B
Charleston, SC 29407
Phone: (843) 571-7951

Patient Information

Date:_____

Patient Name:_____
First MI Last
Social Security #:_____
Sex: □ Male □ Female Age:_____
Birthdate:_____
Address:_____
City:_____
State: _____Zip Code:_____

Email:_____

Occupation:_____
Employer/ School:_____
Employer/School Address:_____
_____

□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered

Spouse's Name:_____
Spouse's Birthdate:_____
Spouse's Social Security #:_____
Spouse's Employer:_____

Whom may we thank for referring you?
_____

Who is responsible for this account?_____

Relationship to patient:_____

Insurance Company:_____
Group/Plan #:_____

Is patient covered by additional insurance? □Yes □No
Subscriber's Name:_____
Birthdate:_____ SS#:_____
Relationship to Patient:_____
Insurance Company:_____
Group #:_____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise 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 submissions.

The above named dentist my 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.

Signature of Patient or Guardian:_____
Pleast print name: _____
Date:_____ Relationship to Patient:_____

Phone Numbers

Home: (_____)_____
Work: (_____)_____Ext_____
Cell: (_____)_____
Spouse's Work: (_____)_____
How would you prefer we contact you?_____
_____

IN CASE OF EMERGENCY, PLEASE CONTACT:
Name:_____
Relationship:_____
Home:_____
Work:_____
Cell:_____