

LAURA WAGNER, MD

PATIENT REGISTRATION FORM

New Patient

Return Patient with... **Name Change** **Address Change** **Phone Change** **Insurance Change**

Patient Information

Last Name:	First Name:	MI:	AGE:
Address:			
City:	State:	Zip:	
Birthdate:	Social Security#:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino
Marital Status:	<input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widow		
Home Ph#:	Work Ph#:	Cell Ph#:	
Preferred Language:	e-mail:		

Emergency Contact

Name:	Relationship to you:	Phone:
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INSURANCE INFORMATION:

The member is the employee if the policy is issued through work.

The member is the patient if you have an individual policy purchased outside of a group, or if you have Medicare or Supplement.

You must present your insurance card(s) and complete this section if you want us to file to your insurance.

♦ indicates this information is required to file a claim.

Primary Insurance Coverage/Member Info

Insurance Company Name:			
Member Information			
♦ Name of Policy Holder (member):			
Social Security#:			
♦ Birthdate:			
♦ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Home Ph#:	Work Ph#:	Cell Ph#:	
♦ Patient Relationship to the member: the patient is... <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

Secondary Insurance Coverage/Member Info

Insurance Company Name:			
Member Information			
♦ Name of Policy Holder (member):			
Social Security#:			
♦ Birthdate:			
♦ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Home Ph#:	Work Ph#:	Cell Ph#:	
♦ Patient Relationship to the member: the patient is... <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

Primary Care Physician

Primary Care Physician Name:	Phone#:
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Referring Physician – please provide the following information if a physician referred you.

Referring Physician Name:	Phone#:
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Pharmacy Information

Pharmacy Name:	Phone#:
Pharmacy address:	

Signature of Patient or Responsible Person

Date