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: ☐ Male ☐ Female	
Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander	☐ Asian ☐ White	☐ Black or African American	☐ Hispanic or Latino
Marital Status: ☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widow			
Home Ph#:	Work Ph#:	Cell Ph#:	
Preferred Language:	e-mail:		

Emergency Contact

Name:	Relationship to you:	Phone:

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: ☐ Male ☐ Female		
Home Ph#:	Work Ph#:	Cell Ph#:
◇ Patient Relationship to the member:	the patient is... ☐ Myself ☐ Spouse ☐ Child ☐Other	

Secondary Insurance Coverage/Member Info

Insurance Company Name:		
Member Information		
◇ Name of Policy Holder (**member**):		
Social Security#:		
◇ Birthdate:		
◇ Gender: ☐ Male ☐ Female		
Home Ph#:	Work Ph#:	Cell Ph#:
◇ Patient Relationship to the member:	the patient is... ☐ Myself ☐ Spouse ☐ Child ☐Other	

Primary Care Physician

Primary Care Physician Name**:**	Phone#:

Referring Physician – please provide the following information *if* a physician referred you.

Referring Physician Name:	Phone#:

Pharmacy Information

Pharmacy Name:	Phone#:
Pharmacy address:	

Signature of Patient or Responsible Person ***Date***

☐ **scanned**