

Laura Wagner, MD  
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phone (314) 434-1111  
fax (314) 434-1112

*Welcome! ...and thank you for scheduling your appointment with Dr. Laura Wagner.*

Please complete these forms and bring them with you to your appointment. The information that you provide here will be used to file claims to your insurance, create your patient chart, and help us to provide quality care to you. Be sure to answer all questions completely and remember to sign the forms.

**CHECK LIST OF WHAT TO BRING**

- Completed enclosed forms:** Patient Registration Form; Health Questionnaire; Policy & Consent Form.
- Insurance Cards:** If you have two insurances, you'll need to know which is primary.
- Photo ID:** This is required for proof of identity; a driver's license or other photo ID is acceptable. (If the patient is a minor without a photo ID, we can accept an ID from the responsible party.)
- Co-Pay:** If required by your insurance. We accept Cash, MC, Visa, Amex, Discover, and Personal Check.
- Non-Covered Services:** Payment is due at the time of service for non-covered services and for self-pay patients
- Written Referral:** If you don't know if you need a referral, contact your insurance. They'll tell you if you need one.

If they do require a referral, you must present it to us before being seen to avoid rejection of your claim. You should request the referral from your primary care doctor as soon as possible. Either bring it with you or have it faxed to 314-434-1112.

If a referral is required, but not available at the time of your visit, you will have 2 options:

1. Reschedule the appointment.
2. You can keep your appointment. We will note your account that no referral was presented. We will file your claim, but if your claim denies because of no referral, you would be responsible for payment in full.

- Minor Children:** A minor child is under the age 18. If a legal guardian will not be present at the visit, please send everything on the check list plus written permission to treat your child & phone# where you can be reached.

**WHAT TO EXPECT WHEN YOU CHECK-IN**

- We will take your completed registration forms (and referral if required).
- We will scan your insurance card(s) and photo ID.
- We will take your picture for your electronic record.

**PLEASE STOP AT THE CHECK-OUT DESK AFTER YOUR APPOINTMENT. We will...**

- Collect your co-pay if required.
- Schedule follow-up appointments if needed.
- Have you sign Medical Release forms if necessary.
- Provide written Rx if necessary.
- Provide written excuses for work or school.
- Provide electronic access to your chart.

**Please be sure to read the Policy & Consent Form for information about...**

**1) Patient Responsibility & Billing Policy**

**2) Authorized Contacts**

**3) Assignment of Benefits**

**4) Disclosure of Protected Health Information**

**5) Medical Consent**

**Severe Weather:**

*Please note: In the event of severe weather, we will try to notify you if we are closing. Please be sure to call us or check our website if the weather is questionable and you don't hear from us.*

See back side for driving directions. Do Not mail these forms.

Date \_\_\_\_\_

Please answer each question.

LAURA WAGNER, MD

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ AGE: \_\_\_\_\_

Sex:  Male  Female Birthdate: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_  Mobile: \_\_\_\_\_  Work: \_\_\_\_\_

Patient email: \_\_\_\_\_

Contact Preference:  Home Phone  Work Phone  Mobil Phone  Mail  Portal

Preferred Language:  English  Other \_\_\_\_\_

Race:  American Indian  Asian  Asian Indian  Asian  Black/African American  European  Filipino  
 Jananese  Korean  Native Hawaiian/Pacific Islander  White

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino

Marital Status:  Married  Single  Divorced  Legally Separated  Widowed  Partner

AUTHORIZED CONTACT INFORAMTION

GUARANTOR information (to whom statements are sent) required information

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security#: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

EMERGENCY CONTACT information optional

Name: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Additional Contacts optional  GUARDIAN or  NEXT OF KIN

Name: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

OTHER

Primary Care Physician Name: \_\_\_\_\_ Ph#: \_\_\_\_\_

Referred by physician?  Yes  No Physician Name: \_\_\_\_\_ Ph#: \_\_\_\_\_

Default Pharmacy

Pharmacy Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Preferred Lab

Quest  LabCorp  Lab One  Other \_\_\_\_\_

Referrals

Does your insurance require a referral to see a specialist?  Yes  No If yes, did you provide a referral?  Yes  No

INSURANCE INFORMATION

Primary Insurance

Insurance Company: \_\_\_\_\_ Relationship to patient:  Myself  Spouse  Child  Other

Member Name: \_\_\_\_\_ Group#: \_\_\_\_\_

Member Birthdate: \_\_\_\_\_ Member SSN#: \_\_\_\_\_ Member Sex:  Male  Female

Secondary Insurance

Insurance Company: \_\_\_\_\_ Relationship to patient:  Myself  Spouse  Child  Other

Member Name: \_\_\_\_\_ Group#: \_\_\_\_\_

Member Birthdate: \_\_\_\_\_ Member SSN#: \_\_\_\_\_ Member Sex:  Male  Female

Note: The 'Financial & Billing Policy, Disclosure & Consent Form' explains your responsibilities and how your information is used.

SIGN: X \_\_\_\_\_

Signature of Patient (or guardian if patient is a minor)

Relationship to Patient

Date \_\_\_\_\_

Please answer each question.

LAURA WAGNER, MD  
Health Questionnaire

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

**HABITS - check one box for each line.**

- Smoking Status:**     Current Daily     Current Occasional     Heavy     Light     Never     Former
- Alcohol Consumption:**     None     Social     Heavy
- Females only, check one:**     Pregnant     Trying to conceive     Nursing     None of these

**MEDICATIONS & ALLERGIES:**

Do you currently take any prescription **Medications**?     Yes     No

LIST PRESCRIPTION NAME AND STRENGTH

LIST PRESCRIPTION NAME AND STRENGTH

_____	_____
_____	_____
_____	_____
_____	_____

Do you have any **Drug Allergies**?     Yes     No

LIST PRESCRIPTION NAMES & REACTION TO DRUG

\_\_\_\_\_

\_\_\_\_\_

Check allergies to those that apply:     Latex     Tape     Band-aids

**PERSONAL HISTORY OF SKIN CANCER:**

- Melanoma     Squamous Cell Carcinoma     Basal Cell Carcinoma     Actinic Keratosis (pre-cancers)

List year & location of cancer: \_\_\_\_\_

**FAMILY HISTORY OF SKIN CANCER:    (Include only if parent, full sibling, or child)**

NO KNOWN FAMILY HISTORY

MELANOMA

RELATIONSHIP TO YOU: \_\_\_\_\_

SQUAMOUS CELL CARCINOMA

RELATIONSHIP TO YOU: \_\_\_\_\_

BASAL CELL CARCINOMA

RELATIONSHIP TO YOU: \_\_\_\_\_

**Have you been treated for other SKIN PROBLEMS IN THE PAST:**     Yes     No    LIST PROBLEMS & APPROXIMATE ONSET DATES.

\_\_\_\_\_

\_\_\_\_\_

**Have you had any MAJOR SURGERIES?**     Yes     No    LIST SURGERIES & YEAR.

\_\_\_\_\_

**HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING:**     Yes     No    Check all that apply. Give approx onset date.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> GLAUCOMA               | <input type="checkbox"/> COLITIS              | <input type="checkbox"/> THYROID DISEASE                                       |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> G.E.R.D.             | <input type="checkbox"/> BLOOD THINNERS / Aspirin / Coumadin / Plavix / Other: |
| <input type="checkbox"/> HEART DISEASE          | <input type="checkbox"/> HEPATITIS A/B/C      | <input type="checkbox"/> AIDS / HIV  |
| <input type="checkbox"/> HYPERTENSION           | <input type="checkbox"/> KIDNEY DISEASE       | <input type="checkbox"/> ARTIFICIAL JOINT                                      |
| <input type="checkbox"/> STROKE                 | <input type="checkbox"/> SEIZURES             | <input type="checkbox"/> CHEMOTHERAPY  |
| <input type="checkbox"/> PACEMAKER              | <input type="checkbox"/> MIGRAINES            | <input type="checkbox"/> RADIATION THERAPY                                     |
| <input type="checkbox"/> DEFIBRILLATOR          | <input type="checkbox"/> DIABETES MELLITUS    | <input type="checkbox"/> ORGAN TRANSPLANT                                      |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> HERPES SIMPLEX VIRUS | <input type="checkbox"/> CANCER... other than skin / what type?                |
| <input type="checkbox"/> EMPHYSEMA              | <input type="checkbox"/> LIVER DISEASE        | <input type="checkbox"/> OTHER CONDITION: Please List:                         |

**SIGN: X** \_\_\_\_\_

Signature of Patient (or guardian if patient is a minor)

Relationship to Patient

Check here if you have provided attachments.

Check here if you used the back side of this form.

