

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