Date_____ Birthdate_____ Age_____

Legal Name_____/_____/_____ Maiden Name_____
first middle last

Single_____ Married_____ Widowed_____ Divorced_____

Check all that apply in how we may contact you: Home # ____ Cell # ____ Email ____ Mail ____

Home Phone #_____ Work Phone #_____

Cell Phone#_____ Email Address: _____

Home Address_____City_____State_____Zip Code_____

Driver's License_____ Last 4 Digits of SSN_____

Employed By_____ Address_____

Occupation_____

Pharmacy Name_____ Pharmacy Telephone #_____

Mail Order Name_____ Mail Order Telephone #_____

Primary Care Physician: _____ Telephone #_____

Please List Any Other Physicians You See_____

Please List Known Allergies_____

Name of Medical Insurance _____

Member ID _____ Group # _____

List Insurance Holder's Information (if different from patient)

Name _____ Birthdate _____

************THERE WILL BE A $25 CHARGE FOR ANY NO SHOW APPOINTMENTS***********

I authorize payment of medical/surgical benefits to K. Steven Wagner, M.D. In the event that there is a difference between the professional fees and the amount paid by my insurance company for covered benefits, I WILL BE ULTIMATELY RESPONSIBLE FOR THE UNPAID PORTION OF MY BILL.

_____
Signature

Note to Patient's Under the Age of 18: You must have the consent of a parent or legal guardian before you can be seen and treated in this office.

Revised 04/2018