K Steven Wagner M.D.

Patient Name:_______________________________ DOB: _______________

EMERGENCY CONTACT

I would like the following Person(s) to be contacted in case of an emergency:

Name:___________________________ Relationship:_____________________

Phone #: _________________________ Alternative Phone #:_______________

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

_______ I do not authorize release of my medical information to anyone but myself.

_______ I authorize release of my medical information (please fill out below)

Name:______________________________ Relationship: ____________________

Name:______________________________ Relationship: ____________________

Patient (Guardian) Signature: __________________________ Date: ______________