Martin H. Wagner, M.D.

Patient Registration

Patient Name _____ Home Phone ( )_____

Street Address _____ Apt#_____ Cell Phone ( )_____

City _____ State _____ Zip _____ Date of Birth _____ Age _____

Social Security# _____ Marital Status: single/married/divorced/widowed Male/Female

Spouse's Name _____ or Parent's Name (if a minor) _____

Spouse's Social Security# _____ Spouse's Date of Birth _____

Emergency Contact Name _____ Relationship _____Phone_____

Nearest Relative not living with you _____ Relationship _____Phone_____

Employment Information

Name of Place of Employment _____

Address _____ City _____ State _____ Zip _____

Phone ( ) _____ Occupation _____

Insurance

Primary Insurance: Name and Address _____

Insured's Name _____ ID _____ Group#_____

Secondary Insurance: Name and Address _____

Insured's Name _____ ID _____ Group# _____

Workers Compensation

CLAIMS WILL NOT BE FILED FOR WORKERS COMPENSATION WITHOUT THIS INFORMATION

Date of Incident _____ Workers Compensation Claim No: _____

Name of Claim Officer handling this claim _____ Phone: ( ) _____

Name and Address where incident occurred_____

Insurance Authorization and Assignment

I hereby authorize Martin Wagner, M.D. to furnish any medical information necessary to process claims to my insurance carriers, and I hereby assign to Martin Wagner, M.D. all payments for medical services rendered to me by him. I also understand that I am responsible for any amount not covered by insurance. If I have Medicare, I authorize payment of Medicare benefits to be made to Martin Wagner, M.D. for any medical services furnished to me by him. I also authorize the release of any medical information needed to determine these benefits to Medicare.

Patient Signature_____ Date:_____