

Richard M. Wagner, D.D.S.
Oral Surgery and Dental Implant Specialists
PATIENT REGISTRATION

PATIENT NAME _____ DATE OF BIRTH _____ SS# _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE (HOME) _____ (CELL) _____ (WORK) _____
PLEASE CIRCLE ONE: MARRIED SINGLE WIDOWED DIVORCED
EMPLOYER _____ POSITION/DEPT _____ ADDRESS _____
IF FULL TIME STUDENT: SCHOOL _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

RELATIONSHIP TO PATIENT: SPOUSE PARENT OTHER _____
NAME _____ DATE OF BIRTH _____ SS# _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE (HOME) _____ (CELL) _____ (WORK) _____
PLEASE CIRCLE ONE: MARRIED SINGLE WIDOWED DIVORCED
EMPLOYER _____ POSITION/DEPT _____ ADDRESS _____

- **PLEASE PROVIDE US WITH YOUR CURRENT INSURANCE INFORMATION BELOW. LIST ANY SECONDARY COVERAGE ON THE BACK OF THIS FORM.**
- **IF THERE ARE MULTIPLE INSURANCE COMPANIES INVOLVED, IT IS YOUR RESPONSIBILITY TO INFORM US HOW YOU WOULD LIKE US TO FILE YOUR CLAIMS. AS A GENERAL RULE, WE WILL FILE TO MEDICAL FIRST AND DENTAL SECOND.**

PRIMARY MEDICAL INSURANCE COMPANY NAME: _____

PLEASE CIRCLE WHICH APPLIES: HMO PPO FREE STANDING
INSURANCE ADDRESS _____ CITY _____ ST _____ ZIP _____
GROUP #: _____ MEMBER ID#: _____

PRIMARY DENTAL INSURANCE COMPANY NAME: _____

PLEASE CIRCLE WHICH APPLIES: HMO PPO FREE STANDING
INSURANCE ADDRESS _____ CITY _____ ST _____ ZIP _____
GROUP #: _____ MEMBER ID#: _____

A WORD ABOUT OUR PAYMENT POLICY

Fees for services rendered are due at the time of each visit. For those patients who make claim for insurance coverage, we require twenty (20) percent payment at the time of service. **You will be given a financial agreement after your exam.** We will be happy to do the initial filing of your insurance claims. You need to know your own insurance and its coverages and limitations. We do not know ahead of time what your insurance will cover. The 20% payment is a down payment based on your estimate not the amount you will owe based on your insurance coverage. We will file the whole total of your services to the insurance. If there is an overpayment, we will refund you promptly. If there is a balance, you will be billed.

- **IMPORTANT: If your account balance is over 90 days past due, even if it is still pending insurance, a service charge of 1.5% per month will be added to the outstanding balance. Please read your insurance policy to be sure that you are fully aware of your benefits and network status. You should look upon your insurance realistically as a device that helps in reimbursement for your expenses. It is your company, and it is your responsibility to see that reimbursement is prompt. If you have not heard from your insurance company within 5 weeks from the date of surgery, it is important that you call your insurance to inquire as to the reason for delay. You will be sent a statement from our office monthly so that you know where your account is at all times and so that there is no question about your balance.**

I have read and fully understand the above and assign the release of information for the purpose of payment or insurance benefits and assign payment directly to Dr. Richard M. Wagner. I realize that I am responsible for any charges not covered by insurance. If I receive payment from the insurance company directly, the check is to be endorsed to **Dr. Richard M. Wagner** within five working days of payment.

SIGNATURES:

PATIENT (IF NOT MINOR) _____ **DATE** _____
PERSON RESPONSIBLE FOR
ACCOUNT _____ **DATE** _____

Richard M. Wagner, D.D.S.
Oral Surgery and Dental Implant Specialists
PATIENT MEDICAL HISTORY

Today's Date: _____

Patient's Name: _____ Form completed by: _____

Who referred you: _____ Your Dentist is: _____ Your Physician is: _____

In case of emergency call: _____ Relationship: _____ Phone: _____

Patient's age: _____ Height: _____ Weight: _____

Please circle "Yes or "No" If there are any questions that you don't understand, please ask.

Yes No Are you in good health?

Yes No Have you been under a physician's care in the past year?

Yes No Have you been on any prescription medications in the past year?

Yes No Do you take aspirin or anti-inflammatories (such as ibuprofen) on a regular basis?

Yes No Have you ever had an unusual or allergic reaction to a medication?

Yes No Have you ever had surgery?

Yes No Have you ever had anesthesia?

Yes No Have you or a family member ever had complications with anesthesia?

Yes No Have you ever been seriously ill?

Yes No Have there been any changes in your health this year?

Yes No Do you bleed a long time when you are cut?

Yes No Do you bruise abnormally?

Yes No Have you had a cough or cold in the past week?

Yes No Are you pregnant?

Yes No Are you taking birth control pills?

Do you have, or have you ever had, any of the following:

Yes No Rheumatic fever, rheumatic heart disease

Yes No Heart trouble, heart attack, stroke

Yes No Heart pacemaker

Yes No Heart murmur

Yes No Chest pain, shortness of breath,
swollen ankles

Yes No High blood pressure

Yes No Low blood pressure

Yes No Bleeding disorders, anemia

Yes No Sickle cell disease or trait

Yes No Diabetes

Yes No Asthma, hay fever

Yes No Stomach ulcers

Yes No Thyroid problems

Yes No Pneumonia, tuberculosis, or other
lung disease

Yes No Kidney problems

Yes No Hepatitis, jaundice, liver disease

Yes No Fainting spells, seizures, epilepsy

Yes No Concussion or head injury

Yes No Glaucoma or other eye problems

Yes No Sexually transmitted disease

Yes No Tested positive for Immune disease
(such as: AIDS or HIV)

Yes No Injury to face, jaws or teeth

Yes No Frequent headaches

Yes No Jaw joint problems: (such as:
joint noises, locking, pain)

Yes No Oral surgery, Orthodontics or
Periodontal (gum) surgery

Please answer the following (Circle):

Alcoholic Beverages: Never Rarely Socially Daily

Cigarettes: Yes No If yes: Packs per day: _____

Never Smoked

Other tobacco use: Pipe Chewing

Do you have an allergy or sensitivity to medications?

None Known

Yes No Penicillin

Yes No Codeine

Yes No Anesthetics

Yes No Aspirin

Yes No Others: _____

Yes No Do you have any disease or condition, or concerns not listed above that I should know about?

Please explain: _____

Thank You!

Richard M. Wagner, D.D.S.
Oral Surgery and Dental Implant Specialists
1925 South Green Bay Road
Racine, WI 53406
(262) 634-4646 • (262) 654-4222

MEDICATION LIST

Patient Name: _____ Today's Date: _____

MEDICATION NAME:	HOW MANY TIMES A DAY?	DOSE mg. ?	PRESCRIBED BY DR.:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Special Notes:

Patient's Signature: _____