

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 1ST AND DENTAL 2ND.**

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 which 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** _____