

Joseph L Wagner III, DMD
 4882 Brownsboro Med. Ctr.
 Louisville, KY. 40207-2342

Patient Information

Name _____			Date _____		
Address _____			Age _____	Birthdate _____	Sex _____
City _____ State _____ Zip _____			<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Home Phone _____ Business Phone _____			Patient's Social Security Number (Or Guardian's) _____		
Occupation _____			Spouse's Name _____		
Employed By _____			Employed By _____		
Employer's Address _____			Friend/Relative Not Living With You _____		
City _____ State _____ Zip _____			Phone _____ Address _____		
			Family Physician _____		

Person Responsible For Bill

Name _____			Occupation _____		
Address _____			Employed By _____		
City _____ State _____ Zip _____			Employer's Address _____		
Phone _____			City _____ State _____ Zip _____		
Relationship To Patient _____			Business Phone _____		

*** Primary Dental Insurance**

Policy Holder _____	Birth Date _____
Employer's Name _____	
Insurance Company Name _____	
Insurance Company Address _____	
City _____	State _____ Zip _____
I.D. # (SS #) _____	Policy or Group # _____

Secondary Dental Insurance

Policy Holder _____	Birth Date _____
Employer's Name _____	
Insurance Company Name _____	
Insurance Company Address _____	
City _____	State _____ Zip _____
I.D. # (SS #) _____	Policy or Group # _____

Referral Source

<input type="checkbox"/> Physician _____ Name _____	<input type="checkbox"/> Newspaper Ad _____	<input type="checkbox"/> Yellow Pages _____
<input type="checkbox"/> Friend _____ Name _____	<input type="checkbox"/> School Programs _____	<input type="checkbox"/> Open House/ Special Events _____
<input type="checkbox"/> Relative _____ Name _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Location (Please Specify) _____

Release Information

I understand terms are cash for services rendered (if these terms create a problem please see the business office about making other arrangements before you are examined). I will be responsible for all charges incurred by me. I hereby assign and authorize insurance payment directly to Dr Joseph Wagner. All benefits payable under the terms of any insurance policy listed above. I realize the insurance benefits may not pay all the bill and I agree to pay the difference or the entire bill if necessary. I authorize the release of any dental information necessary to process claims on any insurance policy listed above.

SIGNATURE _____ DATE SIGNED _____