Wagner Pediatric Dentistry, LLC
130 W Silver Spring Dr. #200
Whitefish Bay, WI 53217
P: 414-939-3870 F: 414-967-4864
office@wagnerpediatricdentistry.com

PATIENT INFORMATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Preferred:	❑ Male ❑ Female	Birth date: / /

Street address:	Email Address (for all correspondence):	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:
Parent 1 Name:	Parent 1 Cell: ( )	Parent 1 Employer:	Parent 1 Birth date: / /
Parent 2 Name:	Parent 2 Cell: ( )	Parent 2 Employer:	Parent 2 Birth date: / /

Referred to our office by (please check one box): ❑ Dr. _____ ❑ Facebook

❑ Family ❑ Friend ❑ Location/Sign ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Dental Insurance Co Name:	Insurance Co Address:	City, State and ZIP	Ins Co phone no.: ( )
Employer Name:	Employer address:	Employer phone no.: ( )	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Allow for direct payment to Wagner Pediatric Dentistry, LLC ❑ Yes

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wagner Pediatric Dentistry, LLC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*