David V. Wagner, M.D
409 Summit Suite 2800

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Phone: 605-655-1220

# PATIENT INFORMATION

Legal Last    Legal First    Legal Full Middle

Maiden Name/Other Name

Address    Apt. #

Address

City    State    Zip Code

(    )    (    )
Home Phone    Cell Phone

Date of Birth (Mo/Dy/Yr) Sex (M/F)    Marital Status

E-mail address    Race

Social Security Number    Religion

Church Membership or Affiliation

Primary Language    Ethnicity

Employer

Address

Address

City    State    Zip Code

(    )    Yes    No (circle one)
Work Phone    Can we call this number?

Occupation

Employment Status (Full, Part, Retired, Etc.)

Your Primary Care Physician

Primary Care Physician's Clinic Name and City

NEXT OF KIN:

Last    First    Full Middle Name

Address

Address

City    State    Zip Code

(    )    (    )
Home Phone    Work Phone

Relationship to Patient

PERSON TO NOTIFY IN AN EMERGENCY:

Last    First    Full Middle Name

Address

Address

City    State    Zip Code

(    )    (    )
Home Phone    Work Phone

Relationship to Patient

## RESPONSIBLE PARTY INFORMATION

List the person's name you want your monthly statements addressed to. If you want family billing, this name must be the same for all family members.

Last First Full Middle Name

Address

Address

City State Zip Code

( )
Home Phone

E-mail address Race

Social Security Number

Relationship to Patient

Employer

Address

Address

City State Zip Code

( )
Work Phone

Occupation

Employment Status (Full, Part, Retired, Etc.)

*If this visit would be billed to someone other than you or your health insurance, please notify the front desk BEFORE you see the provider.*

## INSURANCE INFORMATION

PRIMARY INSURANCE POLICY:

Name of Insurance Co. Insured ID number

Name of subscriber Subscriber's SSN

Policy Effective Date Subscriber date of birth

Subscriber's Employer Relationship to the Patient

SECONDARY INSURANCE POLICY:

Name of Insurance Co. Insured ID number

Name of subscriber Subscriber's SSN

Policy Effective Date Subscriber date of birth

Subscriber's Employer Relationship to the Patient

TERTIARY INSURANCE POLICY:

Name of Insurance Co. Insured ID number

Name of subscriber Subscriber's SSN

Policy Effective Date Subscriber date of birth

Subscriber's Employer Relationship to the Patient

Do you have a living will? Y N Unsure More Info

Power of attorney? Y N Unsure More Info

Advanced Directive? Y N Unsure More Info

## FAMILY LISTING

Please list other family members in the household (optional).

| Last | First | Full Middle Name | Last | First | Full Middle Name |
|---|---|---|---|---|---|
| Date of Birth | Relationship to Guarantor | | Date of Birth | Relationship to Guarantor | |
| Last | First | Full Middle Name | Last | First | Full Middle Name |
| Date of Birth | Relationship to Guarantor | | Date of Birth | Relationship to Guarantor | |
| Last | First | Full Middle Name | Last | First | Full Middle Name |
| Date of Birth | Relationship to Guarantor | | Date of Birth | Relationship to Guarantor | |

RELEASE OF INFORMATION

I authorize the release of medical information to the following family members (if none, write "none" in the first blank)

| | |
|---|---|
| | |
| | |
| | |
| Signature | Date |

The undersigned authorizes payment to Avera Foot & Ankle Clinic of any insurance benefit otherwise payable to patient, but not to exceed regular charges for such services. All release of information will be in accordance with the Avera Sacred Heart Notice of Privacy Practices and I acknowledge I have received a copy. All patient accounts will be considered due upon receipt or your itemized bill. As a courtesy to me, the Business Office will process my insurance if information is provided. I will be billed on the current balances of my account regardless of the insurance claim status. Accounts over thirty (30) days old may bear interest at a rate allowed under South Dakota or Nebraska State Law. Accounts of ninety (90) days old may be referred to an attorney of an agency for collection at which time the undersigned shall be responsible for all responsible attorney's fees and expenses. I hereby give my informed consent to the Clinic to receive medical services from physicians, nurses and other medical staff at the Clinic. This consent shall be effective until I revoke it. I understand that I may evoke this consent in writing at any time except to the extent that medical services have already been provided to me at the Clinic.

Signed: _______________________________ Date: _______________

Patient or Authorized Person