Place patient label here.

IGO MEDICAL GROUP

PATIENT REGISTRATION AND DEMOGRAPHIC INFORMATION

Full Name (first, middle, last) ____________________ Social Security # ____________________

Sex ________ Date of Birth ____________ Current Age ___________ Maiden Name ____________________

Address ____
Street City State ZIP

Home Phone ____________________ Cell Phone ____________________ Work ____________________

Email ____

Preferrred number for phone calls: ☐ Home ☐ Cell ☐ Work Can message be left? ☐ Yes ☐ No
Preferred method for Auto-Reminder Communications: ☐Home phone ☐Cell (text) ☐Cell (voice mail) ☐Email

Birth Place ____________________ Preferred Language ____________________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Hispanic? ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Provide

Race (check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race or Mixed Race ☐ Decline to Provide

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Referred to IGO by: ☐ Dr. ____________________ ☐ Friend/Patient of IGO ____________________ ☐ Insurance Company

Person to Notify in Case of Emergency ____________________ Relationship ____________________

Phone ________________ Address ____

Patient's Driver's License # ____________________ Occupation ____________________

Employer ____________________ Employer Phone ____________________

Employer Address ____
Street City State ZIP

Full Name of Insurance Subscriber (Guarantor) ____

☐ Self ☐ Spouse ☐ Parent ☐ Other ____________________ Subscriber Social Security # ____________________

Subscriber Sex ________ Subscriber Date of Birth ____________________ Subscriber Phone ____________________

Subscriber Employer ____________________ Occupation ____________________

Employer Address ____________________ Work Phone ____________________

Insurance Company ____________________ Subscriber # ________________ Group # ____________

AUTHORIZATION TO PAY PHYSICIAN AND ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major benefits to which I am entitled, and authorize payment directly to IGO Medical Group, AMC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will remain as valid as the original. I hereby authorize IGO Medical Group to release all information necessary to my insurance companies to secure payment.

I understand that I am financially responsible for all charges incurred whether or not covered by my insurance.

Signature ____ Date ____________________