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. _____ ☐ Frient/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 insurnace companies to secure payment.

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

Signature _____ Date _____