Small Miracles Everyday

IGO & Infertility, Gynecology & Obstetrics

MEDICAL GROUP, AMC.

9339 Genesee Avenue
Suite 200 & 220
San Diego, California
(858) 455-7520
Fax (858) 554-1312

PATIENT INFORMATION

FULL NAME ____________________ MAIDEN NAME ____________________

☐ SINGLE ☐ MARRIED **DATE OF BIRTH** ____________ **SEX** ______

☐ SEPARATED **PLACE OF BIRTH** ____________________

☐ WIDOWED ☐ DIVORCED **CURRENT AGE** __________

ADDRESS ____________________ **HOME PHONE** ______________

____________________ **OCCUPATION** ______________

EMPLOYER ____________________

ADDRESS ____________________ **WORK PHONE** ______________

PATIENT'S INSURANCE CO. ____________________ **SOCIAL SECURITY #** ______________

MEMBER/CERT. NUMBER ____________________

GROUP NUMBER ____________________ **DRIVER'S LICENSE #** ______________

REFERRED TO IGO BY: Dr. ______________ ☐ FRIEND/PATIENT ______________

☐ INSURANCE CO. ______________ ☐ YELLOW PAGES ☐ TV/RADIO ☐ OTHER______________

PERSON TO NOTIFY IN CASE OF EMERGENCY ____________________

ADDRESS ____________________ **PHONE** ______________

RELATIONSHIP ____________________

INSURANCE SUBSCRIBER INFORMATION

☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **OTHER** ______________

FULL NAME OF SUBSCRIBER ____________________ **DATE OF BIRTH** ______________

EMPLOYER ____________________ **OCCUPATION** ______________

ADDRESS ____________________ **WORK PHONE** ______________

INSURANCE CO. ____________________

MEMBER/CERT. NUMBER ____________________ **SOCIAL SECURITY #** ______________

AUTHORIZATION TO PAY PHYSICIAN AND ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical 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 an original. I hereby authorize IGO MEDICAL GROUP to release all information necessary to my insurance companies to secure the payment.

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

SIGNED ____________________ **DATE** ______________

Please arrive 30 minutes early with these forms completed and your current insurance card.